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*“Evaluation of outpatient child-adolescent mental
health services (CAMHS) in Attica-Greece”*

Dissertation to obtain the Master Degree in Mental
Health Policy and Services

By

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Evaluation of outpatient child-adolescent mental health services (CAMHS) in Attica-Greece

Abstract (English)

Background: Childhood is a critical time for social and emotional development, educational progress and mental health prevention. Mental health for children and adolescents is defined by the achievement of expected developmental, cognitive, social and emotional skills. The development of child-adolescent mental health services (CAMHS) is a necessity for each country, not only as a prevention measure for the wellbeing of people, but also as an investment to the future of countries. Qualitative evaluation of services is the only way to ensure whether services function under quality standards and increase the possibility of better outcomes for their patients.

This study examines the greek outpatient CAMHS against the British Standards of National Institute of Excellence for community CAMHS. The Standards assessed refer to the areas of Assessment, Care and Intervention.

Objectives: The main objectives of the study are 1) to evaluate Greek outpatient CAMHS in the Attica region 2) to promote the evaluation process for mental health services in Greece.

Methods: Due to the fact that Greek services are based on the British model, the tool used was the British self-review questionnaire of Quality Network for Community CAMHS (QNCC). The tool was translated, adapted and posted to services. Twelve out of twenty outpatient CAMHS of Attica (including Athens) responded. Data was collected and performed by the Statistical Package for Social Sciences SPSS.

Results: The study resulted that the CAMHS examined, meet moderately the British Standards of 1) Referral and Access, 2) Assessment & Care planning, 3) Care & Intervention. Two out of twelve services examined, meet the standards of "Assessment and Care" in a higher percentage between 75% and 100%.

Conclusions: The paper describes a satisfactory function of CAMHS in Attica prefecture taking into consideration the extremely difficult political situation of Greece at the time of the research. Strong and weak domains are identified. Also the translation and adaptation of British tools promote the evaluation process and quality assurance of Greek CAMHS.

Key words: Child-Adolescent mental health services, Evaluation, Quality Standards, Quality Assurance, Accreditation.

Evaluación de servicios ambulatorios para la salud mental de niños y adolescentes (Servicios SMNA) en Ática, Grecia

Resumen (Español)

Antecedentes: La infancia es un período crítico para el desarrollo social y emocional, el progreso educativo y la prevención de salud mental. La salud mental infanto-juvenil se define por el logro de ciertas aptitudes de desarrollo cognitivo, social y emocional.

La evolución de los Servicios de salud mental de niños y adolescentes (SMNA) es una necesidad en cada país, no sólo como una medida de prevención para el bienestar de las personas, sino como una inversión en el futuro de los países.

La evaluación cualitativa de los servicios es la única manera de garantizar que los servicios funcionan bajo normas de calidad y aumentar la posibilidad de obtener mejores resultados para sus pacientes.

Este estudio examina los Servicios ambulatorio griego SMNA contra los estándares británicos del Instituto Nacional de Excelencia para Servicios SMNA comunitarios (National Institute of Excellence for community CAMHS).

Los estándares evaluados se refieren a las áreas de Valoración, Asistencia e Intervención.

Objetivos: Los objetivos principales de este estudio son 1) evaluar los Servicios ambulatorio griego SMNA en la región de Ática 2) promover el proceso de evaluación en servicios de salud mental en Grecia.

Métodos: Dado que los servicios griegos están basados en el modelo británico, la herramienta utilizada fue el cuestionario británico de autocrítica de la Red Cualitativa para Servicios Comunitario SMNA (Quality Network for Community CAMHS (QNCC)).

La herramienta fue traducida, adaptada y publicada a los servicios. Doce de los veinte Servicios ambulatorio en Ática respondieron (incluyendo Atenas). Los datos se recogieron y se realizaron por el Paquete Estadístico para Ciencias Sociales (Statistical Package for Social Sciences (SPSS)).

Resultados: El estudio tuvo como resultado que los Servicios evaluados cumplen moderadamente con los Estándares Británicos de 1) Referencia y Acceso, 2) Valoración y Planificación de Asistencia 3) Asistencia e Intervención. Dos de las doce servicios evaluados cumplen con los Estándares de “Valoración y Asistencia” en un mayor porcentaje entre el 75% y el 100%.

Conclusiones: En el estudio se presenta un funcionamiento satisfactorio de Servicios SMNA en la prefectura de Ática teniendo en cuenta la situación política extremadamente difícil de Grecia en el momento de la investigación. Se identifican los dominios fuertes y débiles. Además la traducción y adaptación de las herramientas británico promueven el proceso de evaluación y el aseguramiento de la calidad de los Servicios SMNA griego.

Palabras clave: Servicios de salud mental para niños y adolescentes, Evaluación, Estándares de Calidad, Aseguramiento de la Calidad, Acreditación.

Avaliação dos Serviços de Saúde Mental para Crianças e Adolescentes enquanto Pacientes Externos na região da Attica - Grécia

Resumo (português)

Histórico: A infância é um período crítico para o crescimento emocional e social, o progresso escolar e a prevenção da saúde mental. A saúde mental para crianças e adolescentes é definida pela conquista de capacidades pré-estabelecidas de desenvolvimento e também cognitivas, sociais e emocionais. O desenvolvimento de Serviços de Saúde Mental para Crianças e Adolescentes (SSMCA: CAMHS em inglês) é uma necessidade para qualquer país, não apenas como medida de prevenção para o bem-estar da população, mas também como um investimento para o futuro dos vários países. A avaliação qualitativa dos serviços é a única maneira para estabelecer se os serviços funcionam com padrões de qualidade e se acrescentam o potencial de melhores resultados para os pacientes deles.

Este estudo examina o SSMCA grego para pacientes ambulatoriais segundo os Padrões Britânicos de SSMCA do Instituto Nacional de Excelência para a Comunidade. Os Padrões utilizados fazem referência aos Domínios de Avaliação, Assistência e Intervenção.

Objectivos: Os objectivos principais do estudo são: 1) avaliar o SSMCA grego na região de Ática; e 2) promover o processo de avaliação para serviços de saúde mental na Grécia.

Métodos: Desde que os serviços gregos seguem o Modelo Britânico, a ferramenta utilizada foi o questionário de auto-revisão da Rede de Qualidade para Comunidades SSMCA (QNCC em inglês). A ferramenta foi traduzida, adaptada e enviada para os serviços. Doze dos vinte SSMCA da Ática (Atenas incluído) enviaram respostas. Os dados foram colecionados e geridos pelo Conjunto Estatístico para as Ciências Sociais (SPSS em inglês).

Resultados: O estudo mostrou que os SSMCA examinados atingem moderadamente os Padrões Britânicos de 1) Encaminhamento e Acesso 2) Avaliação e Planificação da Assistência 3) Assistência e Intervenção. Dois dos doze serviços examinados atingem o Padrão «Avaliação e Assistência» em percentagem maior entre 75% e 100%.

Conclusões: O documento descreve a função satisfatória dos SSMCA na prefectura da Ática tomando em conta o contexto político extremamente difícil na Grécia no tempo da pesquisa. Identificam-se áreas fortes e frágeis. No entanto, a tradução e adaptação das ferramentas britânicas promovem o processo de avaliação e a garantia de qualidade dos SSMCA gregos.

Palavras-chave: Serviços de Saúde Mental Crianças-Adolescentes, Avaliação, Padrões Qualidade, Garantia Qualidade, Acreditação.

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INTRODUCTION

«Γηράσκω αεί διδασκόμενος»

As long as I live I learn

SOCRATES

Some definitions

“Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and wellbeing. It is directly related to the level reached and competence achieved in psychological and social functioning” (W.H.O, 2005).

“What is a normal child like? Does he just eat and grow and smile sweetly? No, that is not what he is like. The normal child, if he has confidence in mother and father, pulls out all the stops. In the course of time, he tries out his power to disrupt, to destroy, to frighten, to wear down, to waste, to wangle, and to appropriate . . . At the start he absolutely needs to live in a circle of love and strength (with consequent tolerance) if he is not to be too fearful of his own thoughts and of his imaginings to make progress in his emotional development.”

“Child-adolescent psychiatry is a speciality on its own account, concerned with the emotional development of the individual child and with the interferences with maturational process that come from the environment and from conflict within the child” (Winnicott D.)

Children’s and adolescents’ mental health and wellness are depended on a variety of reasons including the fact that children and youth are reliant on their parents and caregivers for material issues and support. Maturation process is a fact giving uncommon behavior to children and adolescents and sometimes it could be confused as illness. That’s why signs of mental health disorders may be different in youth than in adults.

Mental disorders affect children and youth from all socioeconomic and racial/ethnic backgrounds. No other illnesses damage so many children so seriously. Even though all children and adolescents can experience mental health problems, several factors predispose some children to greater risk for developing a mental disorder (Ontario Centre of Excellence for Child and Youth Mental Health, 2013). Such factors are genetic predisposition, early

year's attachment with the caregiver, maturational environment, abuse, conflicts, war and poverty.

An important consideration is that child development influences the vulnerability to disorders, how disorders manifest themselves and how best they may be treated. Thus a developmental perspective is needed for an understanding of all mental disorders and for the development of an appropriate child and adolescent mental health policy.

Despite the evidence of increased rates of child-adolescent mental health disorders, the Atlas project by WHO, identified only 7.0% of countries (14 of 191) with a clearly articulated specific child and adolescent mental health policy in 2002. On the Atlas, it seems that only 7 out of 66 countries considered representing a continuity of care delivery for children and adolescents. A child and adolescent mental health policy should present the values, principles and objectives for improving the mental health of all children and adolescents and reducing the burden of child and adolescent mental disorders in a population. It should define a vision for the future and help establish a model for action (WHO 2005). Important contrasts exist between world regions. In Europe and in the WHO African Region, for example, 95.8 and 33.3% of countries had some form of child and adolescent mental health policy, and 66.7 and 6.3% of countries an identifiable child and adolescent mental health program, respectively (Atlas WHO).

Lack of human resources for child and adolescent mental health treatment services is a universal problem. In developed countries not many students of medicine choose to specialize in child adolescent psychiatry. Except the low financial reimbursement of child-psychiatrists there is a vague idea of the usefulness of that specialty and for the way of its practice. Psychiatrists from private practices in the USA declare that doctors are paid half of their fee for child assessment without a prescription and this is a reason why medication is over prescribed.

In the developing world there is the wrong idea that a child psychiatrist is a luxury. This could be true if the child-psychiatrist is out of preventive measures and promotion of mental health for children and adolescents. But if a child psychiatrist is part of a team who take care of the above, they can define the emotional and material needs of a child. A child psychiatrist should know how to combine the environment, the resources, the temperament and the age needs of a child in order to have a normal growth.

The United Nations Convention on the Rights of the Child and Adolescent (CRC) is considered the most universally endorsed and comprehensive human rights treaty of all time (Atlas child and adolescent mental health resources WHO 2005). CRC recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community (Article 23.1); The CRC is recognized in both developing and industrialized countries (W.H.O., 2005).

Historically, recognition that children and adolescents have a mental life is of recent origin. Children previously were not recognized as having feelings,

including depression or other mental disorders, such as contact disorder. (WHO 2003). Babies were characterized as a “gastrointestinal tube” meaning that they only eat and defecate. Now we know that even 6 hours after birth they have the ability to record the environment and feeling accordingly. Efforts are needed to get objective information and to sensitize parents, providers of care and specialists.

It is clear that understanding normal and deviant human brain development in the context of the environment across time is not a simple task (Polanczyk, 2014). The theory of brain plasticity has changed a lot the mentality of unrecovered cases. We know now that children can develop their brain more than their genetic predisposition and recover traumas from life-events (Ansermet 2012).

Child-adolescent psychiatry should continue to support children and adolescents to live a joyful, creative and thinkable life. Several systems of care (e.g. education, welfare, health) need to be involved to ensure the effectiveness of mental health services.

This dissertation presents a study in outpatient children-adolescent mental health services (CAMHS) in Greece, taking as a model the British Tier 3 Services. The T3 service is usually provided by a multi-disciplinary team or service working in child psychiatry outpatient service or community settings. They offer a specialized service for those with more serious, complicated and tenacious disorders.

The research part of this dissertation is to examine the Greek outpatient Children-Adolescents Mental Health Services (CAMHS) against the British National Standards for community CAMHS.

The CAMHS in Greece refer to a population of 0 to 18 year old. Some of them don't deliver services to all that spectrum of ages and others extend the spectrum to 23 years, including youth.

The services examined are in Attica prefecture (the region includes the capital of Greece, Athens). The research exams 12 out of 20 services. The British Standards (3th editions of National Network of Excellence 2012) translated and adapted to Greek reality.

The Standards assessed are referred to the areas of **Access, Care and Intervention** and it is an effort to identify the strong domains of Greek CAMHS and the domains which take ameliorations.

CONTEXT

CHILD-ADOLESCENT MENTAL HEALTH IN THE WORLD

The children and adolescent diagnosed with mental health disorders have increased significantly over the past three decades (Bricker, Schoen Davis, 2004). Throughout the history of the WHO Mental Health Program the attention dedicated to children and adolescents has not been equal with that dedicated to adults and the elderly (Saraceno, Barbato, 1995; W.H.O., 2003). According to the Atlas for child-adolescent mental health (WHO 2005) we know that:

- “• World-wide up to 20% of children and adolescents suffer from a disabling mental illness (WHR, 2000).
- World-wide suicide is the 3rd leading cause of death among adolescents (WHR 2001).
- Major depressive disorder (MDD) often has an onset in adolescence, across diverse countries, and is associated with substantial psychosocial impairment and risk of suicide (Weissman 1999)
- Conduct disorders tend to persist into adolescence and adult life and are frequently associated with delinquency, adult crime and dissocial behavior, marital problems, unemployment and poor physical health (Patterson. DeBaryshe, Ramsey, 1989)”.

Children and young people present a combination of psychosomatic-psychological conditions, complicated by significant social or environmental factors which usually require multi-professional confrontation with significant levels of service planning.

Children and adolescents facing mental health disorders lack access to appropriate services and there are significant doubts about the effectiveness of treatments used and care provision. Also concern about mental health care costs and the high financial demands of child-adolescent services have further complicated the understanding of developing services for children within their communities (Holden, Friedman, & Santiago, 2001).

Although it is clear that many children suffer from a variety of mental health conditions research has documented that only a relatively small percentage of these children receive mental health care (Egger, Angold 2005). The majority of recent researches referred to medication in children and not to establishment of appropriate services (U.S public health services). Many researchers are afraid that the number of young children receiving prescriptions for drugs has increased dramatically over a short period of time, despite the fact that it is not sure that medication is appropriate and affective for children under the age five (Kendall-Taylor, Mikulak, 2009). Also it is a

common acceptance among clinicians that medication in children treats the “annoying” symptoms and not the reasons for disorders.

The mental wellbeing of children and adolescents is affected by multiple aspects of their lives such as physical health and quality of nutrition, wealth and poverty, discrimination, war and conflict – and a whole range of other social and economic factors. But it is also affected by more personal factors. The family – the stability it offers, the stimulus it provides and its values. Then there is the psychological support of the community, including the healthcare system, but also a whole range of local social organizations. And finally there is the school and the educational system of each country which give a shelter to a child who was not born in an appropriate environment (WISH 2015).

It is important to clarify that the mental wellbeing of children and adolescents is a combination of neurobiological factors and genes with the significant influence of environmental issues.

Evidence shows that strengthening protective factors in schools, homes and local communities and improving the quality of mental health care for children and adolescents can make important contribution, not only to improving the developmental outcomes of vulnerable young people but also to enhancing countries’ social capital. Mental well-being is essential to a good quality of life; exposure to adversity at a young age is a risk factor for mental disorders. The mental health issue is dealt with in detail in the “European Mental Health Action Plan” during the regional committee for Europe in the 64th session of Copenhagen 15–18 September 2014.

We can create child-adolescent mental health services in a variety of settings. The more common services are child psychiatric units in hospital out-patient departments, community child-adolescent services, community child and family consultation services and school based services. Day units and in-patient units are less common.

In many countries child mental health services are provided by specialists in secondary and tertiary care settings. Increasing access to mental health care in primary care settings requires a shift in the organization of services and in the allocation of financial and human resources. Community-based and informal care provided mainly by peers, parents, school staff and influential community members. They play a major role especially in terms of community sensitization and promotion of psychosocial well-being.

The primary health care needs a variety of structures in order to provide child mental health. These structures have the same philosophy with the delivery of mental health care for adults. The essential idea is a team working project, consisted of general clinicians, pediatricians, nurses, social workers and generally primary health care staff in consultation and supervision with child-adolescent psychiatrists who assume responsibility for providing care. (Bradley et al. 2007)

Young people use a variety of primary care services, such as maternal and child health outpatient clinics, outreach services for vaccination and growth monitoring, counseling and family planning services. These are all potential entry points for providing mental health promotion and care to children and adolescents in need (Gask, 2005, Salisbury, Johnson, Purdy, et al., 2011)

Child psychiatric services are usually based on the work of a multi-disciplinary team with a range of professionals, including child psychiatrists, psychologists, psychotherapists, social workers, speech therapists and play therapists. Because of the close link between child psychiatric problems and difficulties in areas such as education and social environment, collaboration with other relevant professionals is needed. Also child –adolescent mental health disorders have very often psychosomatic symptomatology. For that reason the liaison of child psychiatry with pediatrics and general doctors is important.

As the field of mental health services research enlarges, it will be important to study new services as they arise. The integration of research into practice may be a great factor of quality care (Hoagwood, Burns, Kiser, et al., 2001) Even since 1996 Hoagwood, Jensen, Petti and al, had classified the literature on outcomes of care for children into two main categories: studies of clinical efficacy for children with particular disorders and studies of the service impact for children with diverse symptoms. These parallel parts of research have come of relative independence from each other, creating an artificial and unproductive split. Each of these research categories gives its own attention to outcomes. The benefits for children will be when service planners and clinicians reach an agreement.

Monitoring quality of care

The definition of standards for and indicators of quality of care is key to assessing the effectiveness of organization of services.

The World Health Organization recently launched the Mental Health Gap Action Program (WHO, 2008). Developmental and behavioral disorders are specifically addressed in the mhGAP intervention package (Servili, 2012).

Mental health of children and adolescent in the US

Recent studies have found that in the US as many as 20% of children in the United States show symptoms of a psychiatric disorder (US. DHHS 1999). Mental health disorders among children and adolescent have received increased interest in the USA after the Surgeon General's warning that "the nation is facing a public crisis in mental healthcare for infants, children and adolescents" (U.S. Public Health Service, 2000). From the mental disorders present in adolescents, anxiety is the most common 32% followed by behavior disorders 19%, mood disorders 14% and substance use disorders 11%. Approximately 40% of adolescents meet criteria for multiple disorders at least once in their life.

Age of onset of all categories of disorders often occurs in childhood (e.g., 6 years old for anxiety disorder) or early to mid-adolescence (e.g., 11 years old for behavior, 13 years old for mood, and 15 years old for substance use disorders) (Merikangas et al., 2010b).

Some history:

Until recently, there has been no evidence to critique, or review in the field of child and adolescent services. The concept of childhood mental illnesses began in the late 19th century. These disorders were seen to children as those to adults ones, until the first part of the 20th century. The first English-language text on child psychiatry was published in 1935 (Kanner L: Child Psychiatry. Springfield, Ill, Thomas, 1935).

The first attempts to assess the use of mental health services by children and adolescents began in the late 1980s.

The first development of child-adolescent mental health services in the USA was state-level activities to create coordinated points of entry for delivery of mental health services, organized under the auspices of the Child and Adolescent Service System Program. The project consisted of a series of values and principles focused on maintaining children in their communities, involving families in delivery and planning of treatments and services, and respecting the cultural relevance of services.

The second development was the creation of a scientific agenda centered on examining the relationship between children's needs for psychiatric care and the availability of such care. The two major efforts in this direction were the Great Smoky Mountains study in USA and the study of methods for the epidemiology of children and adolescents. Both studies found that 4 to 8 percent of children between the ages of 9 and 17 years had severe psychiatric disorders and that only about 20 percent of children with the most serious needs were receiving mental health service (Shaffer, Fisher, Dulcan, et al., 1996; Lahey, Flagg, Bird, et al., 1996)

In Canada

In Canada over 1 million Canadians (3%) live with several mental disorders with high direct (\$4.7 billion) and indirect (\$3.2 billion) economic costs. The alarming situation of mental health services in Canada led to the establishment of the Mental Health Commission of Canada (MHCC) in 2007. The objective was to evaluate and develop a national mental health policy for Canada where special concern has been taken about child-adolescent mental health issues.

According to national data of Centre of excellence in Ontario Canada one in five children and adolescents has a mental health disorder. At least one in ten—or as many as six million children—suffer from a serious emotional disturbance that severely disrupts daily functioning at home, in school, or in the community. However, in any given year less than 20% of these children receive mental health care.

In Australia

Child and adolescent mental health problems are an important public health problem in Australia (Sawyer, 2001). In a 2000 study that specifically targeted the mental health issues of children and adolescents aged 4–17 years, it was

estimated that 14% experience mental health problems. Young people have the greatest burden of mental disorders. This is because more than 75% of all serious mental illnesses occur prior to the age of 25 (information sheet Mental Health Issues 2012)

Just over a quarter (26%) of people surveyed in 2007 aged 16–26 had a mental health disorder compared to only 6% of people aged 75–85 (Sawyer and al 2000).

The vast size of Australia and its large non-urban population requires innovative service development.

Australia has created many school based mental health services and prevention and promotion of mental health is more a public matter than a work for NGO, as it is in European countries.

In Asia

Only in recent years have national and international child psychiatry organizations been established in the Asian region. The Asian Society of Child and Adolescent Psychiatry and Allied Professions (ASCAPAP) was established in 1996.

Based on reports about the systems of care in China, Japan, Korea and the Philippines, each of these countries has a special history concerning child mental health and related service development, but there are some common characteristics of the status in the Asian region: a) many countries still face serious problems of general health and even survival, b) child psychiatry is a new specialty for many countries, c) most disorders classified in DSM-IV and ICD-10 are also found in Asian countries, but there is a need for a better understanding of cultural issues, d) changes in the structure of society (working mothers, growth of economic), e) child bringing up practices vary and are sometimes viewed as inappropriate, f) confusing and often contradictory advice is given by professionals on raising up a child g) states don't have a tradition in recognition of children rights (Hong, Yamazaki, Banaag, 2004).

In Africa

In Africa half of the population is children. Basic needs are not provided and it has no sense to define mental wellbeing for African children and adolescents under war or famine or pandemic situations.

International organizations such as the WHO, the World Psychiatric Association (WPA), the World Federation of Mental Health, the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Children's Fund (UNICEF) play an important role with regard to all aspects of child and adolescent mental health.

In Europe

Mental health disorders are the main factor for disability in young people. More than 10% of adolescents in Europe have some form of mental health problem. Depressive symptomatology is the most frequent disorder in children and adolescents in Europe, followed by anxiety disorders, behavioral (conduct) disorders and substance-use disorders. Europe includes countries with the highest adolescent suicide rates in the world. Suicide is among the leading causes of death among young people (regional committee for Europe 64th session Copenhagen, Denmark, 15–18 September 2014 WHO Europe).

The empowerment of Children and adolescents with mental disorders and their families should become the design of every care system in the world. However, recovery principles are not enough if they only try to fit an implementation guide to the variability of different local contexts. Policy recommendations and accreditation standards should be effectively tailored to support a diversity of stakeholder values (Park, Zafran, Stewart et al., 2014).

CHILD-ADOLESCENT MENTAL HEALTH IN EUROPE

In Europe, on average, one in every 5 children and adolescents suffer from developmental, emotional or behavioral problems and approximately 1/8 have a clinically diagnosed mental disorder.

Unfortunately, newly entered countries in the EU are facing even larger problems in the field of children and adolescents mental health (CAMH).

European WP4 (work package 4) has been developed with the intention of analyzing the situation regarding CAMH in participating countries and identifying obstacles and opportunities to develop evidence based and multi-sector national CAMH policies within the enlarged EU (EWP2008).

Child mental health policies and services in Europe are reinforced by public awareness, social mobilization and advocacy. They are also influenced by other contextual issues such as history about public health care, social and educational policy and services.

Systems of mental health care for child-adolescent in Europe are very much connected with the development of child and adolescent psychiatry as a medical specialty. The post-war era of child-adolescent psychiatrists in Europe had the opinion of a separate medical specialty from adult psychiatry, because they gave emphasis to the child development and treatment by a holistic approach more, than a symptomatology treatment. This view made all the post-war child psychiatrists enrich their specialty with long term training in different kinds of psychotherapy, with psychoanalysis dominating. They developed a high level of provision of care in CAMHS which unfortunately today has been damaged. Due to, time after time, lack of financial support from governments and the pharmaceutical industry and the resistance of practitioners to present evidence based research around the field, the budget for CAMHS decreased.

At the postgraduate level, most countries in Europe report at least one institution of higher education in children and adolescents' mental health promotion and/or mental disorder prevention. However, there are still some countries without any institution providing any training.

Child mental health/child psychiatry is recognized as an independent field from general psychiatry in most of the European countries (and in Finland and Germany 3 distinct disciplines are available: child, adolescent and adult psychiatry). The majority of countries have the division between child-adolescent/ adult psychiatry. There are European countries without child-adolescent psychiatry at all.

The number of child psychiatrists, as well as other child mental health workers, has increased over the last decades in nearly all European countries. The situation in the European countries, however, varies regarding not only to the number of child psychiatrists, but also to the organization of departments and services, and to the research, training and continuing medical education which take place within them.

There is much diversity across Europe in the institutions and organizations involved in implementing policies, services and actions for child and adolescent mental health. Promotion and prevention programs are more often the responsibility of non-governmental organizations such as non-profit organizations or university research departments. Several governmental departments may be involved in developing policy and action in different domains affecting child mental health and well-being. Collaboration across sectors is a great issue and difficulties in this domain affect negatively child-adolescent mental health.

Most of the European countries have administratively separate services of care from promotion and prevention services. For example in French-speaking countries (Switzerland, France), CAMHS are not connected with community education in mental health which consist a part of promotion and prevention. On the contrary, the UK and certain other countries, such as Finland, have integrated institutions combining research and public health competencies in an effort to overcome problems of an uneven collaboration.

Compared to the adult epidemiology, the epidemiology in infants, children and adolescents face additional assessment difficulties. It seems that data is incomplete and not readily comparable due to the different study methodologies used. Different studies at the national level have used a number of different diagnostic scales and methodologies. The categorical classification usually developed to assess the mental disorders (i.e., DSM or ICD) is not generally suitable to describe the psychopathology of children/adolescent. There is a need to go beyond the psychopathology described by DSM or ICD. In child/adolescent psychopathology there are more different incidences to diagnose than in adults and at the same time many incidences are not part of mental disorders but parts of normal development. For the assessment of some disorders multiple informants are required (e.g., child, parent, teachers, clinician), and the prevalence can vary considerably.

As Deighton, Croudace, Fonagy, et al in 2014 report, there are varied literatures on child mental health outcome measures that rely on psychometric tools but no reviews exist that evaluate the psychometric evidence and suitability for use in routine practice of existing tools. Also, there is no sufficient psychometric evidence available to demonstrate that tools could reliably measure both severity and change over time in a developing organism.

These methodological characteristics of the studies seem to alter the rates of children with disorders, children receiving treatment and those who are attending but have not been diagnosed.

By repeating community surveys it is possible to monitor the health of the populations and face the difference in prevalence.

(Child and adolescent mental health in Europe: infrastructures, policy and programs 2008)

Nevertheless the model of development of services in Europe is appropriate enough so that it can be replicated in other parts of the world. The following

conclusions can be drawn: a) the main focus of service delivery is no longer on inpatient care, but on outpatient services, day patient facilities, and complementary services are based on a community level b) specialized services for certain disorders are provided with efficient treatment programs, c) programs in the majority of countries are evaluated, d) the private practice of child and adolescent psychiatry varies depending on country and local circumstances (Remschmidt, Belfer, 2005).

A European Public Health Perspective was THE KIDSCREEN project in 2001-2003. The Kidscreen project was funded by the European Commission within the Fifth Framework Program (FP5). The project was part of the Quality of Life and Management of Living Resources program. The program was built around six specific key actions and generic activities. The Kidscreen project co-operated with the Disabkids project, which was also funded by the European Commission. The main objective of the project was the co-operative European development of a standardized screening instrument for children's quality of life, for use in representative national and European health surveys. The aim is to identify children at risk in terms of their subjective health and to suggest appropriate early interventions by including the instrument in health services research and health reporting.

In 2008, WHO, with the European Union published a study comparing mental health care systems in 42 members of the European region. The report's conclusion that the best policies and practices could be found in the English National Health Service (NHS) based on data provided by central government departments, although outcomes or cost-effectiveness were not assessed. England has among the highest rates of mental health and other social problems in Europe and spends a larger proportion of its health budget on mental health than any other country in the continent (*Policies and Practices for Mental Health in Europe: Meeting the Challenges 2008*). At the time of the EU/WHO study there had been a significant increase in spending on mental health services. While the report highlighted the strengths of the English system, doubts have been starting about the actual quality of care that patients receive influenced by the recent cuts (Loukidou, Mastroyannakis, Power, 2013).

From the official British report in the House of Commons we understand the importance given in CAMHS from the stakeholders. They say that in 2010 many CAMHS had long waiting lists, up to 1000 patients waiting for treatment with approximately 450 waiting over 18 weeks. Only 55% of patients were seen for treatment in 18 weeks. Young people and their parents have described "battles" to get access to CAMHS services, with only the most severely affected young people getting appointments; they also described the devastating impact that long waits for treatment can have. So they have successfully implemented CAPA (Choice and Partnership Approach) to manage capacity, demand and flow through the system of referrals. Now (2014) 100% of patients are seen within 18 weeks with a 4 week average for first appointments (Choice) and an 11.4 week average for commencing treatment (Partnership).

Michael Upsall, a commissioner from Derbyshire, put the argument in financial terms: “For the weekly cost of a bed in a tier 4 placement, we could be talking somewhere between £5,000 and £7,000 a week—£25,000-plus a month. You can provide a lot of bespoke services in the community with a lot less funding than that ... If local commissioners had easier access to that funding earlier, we could make the money go a lot further to prevent—or at the very least delay and shorten—the amount of time that a small number of young people end up in tier 4”.

Tier 2 and 3 services are now being developed more. They should cover specific clinical areas including ASDs, perinatal mental health, and eating disorders, as well as services which currently fall between the Tiers, including pediatric liaison. Support Service and the National Service Framework require that all services should routinely audit and evaluate their work and the results used to inform service development (House of Commons, 2014).

The Section of Child and Adolescent Psychiatry within the Union of European Medical Specialists (UEMS) has developed guidelines for training program development for child and adolescent psychiatrists. The program has been introduced in several countries of the European Union and can serve as a global model. The program identifies specific requirements and provides guidance on monitoring and quality assurance.

CHILD-ADOLESCENT MENTAL HEALTH IN GREECE

1. MENTAL HEALTH IN GREECE

Greece is a small peninsula in the southeastern part of Europe, among traditional West countries and East. Its geopolitical place and history gives it specific characteristics, different from other west European countries. Greek mentality varies, as its place, among progressive modern ideas and conservative misconceptions. For example, although mental disorders are considered as a stigma for a greek family, at the same time, it is supportive and doesn't neglect their ill members.

The population of Greece is 11,183,393 according to the last records of 2011. The proportion of the population under the age of 18 years is 17% and the proportion above age 60 is 19% (UNO, 2009).

The literacy rate is 99% for men and 99% for women (UN Statistics, 2008).

The life expectancy at birth is 77 years for males and 82 years for females (UNO, 2005-2010). The healthy life expectancy at birth is 71 years for males and 82 years for females (UNPD, 2010).

The country is in the High income group (based on 2010 World Bank criteria). The total expenditure on health as a percentage of gross domestic product is 10.62%.

In Greece, mental health disorders are estimated to contribute 26.8% of the global burden of disease (WHO, 2008)

The suicide rate before 2010 for males was 5.9 per 100, 000 population and for females was 1.2 per 100, 000 population.

Mental Health in numbers in 2011 from WHO in 2011:

	Total number of facilities/beds	Rate per 100,000 population	Number of facilities/beds reserved for children and adolescents only	Rate per 100,000 population
Mental health outpatient facilities	148	1.32	34	0.30
Day treatment facilities	45	0.40	13	0.12
Psychiatric beds in general hospitals	570	5.1	UN	UN
Community residential facilities	146	1.31	5	0.04
Beds/places in community residential facilities	UN	UN	UN	UN
Mental hospitals	9	0.08	1	0.01
Beds in mental hospitals	2125	19.0	10	0.09

The health sector in Greece is based on a public and private sector. It has three sub-systems: (a) the National Health System (NHS) providing hospital care throughout the country and primary care coverage, (b) the Social

Insurance Organizations covering different professional groups and (c) the private sector.

The Greek mental health system has changed considerably from the “years of Leros” in 1983. Leros is an island where a huge psychiatric hospital was, with totally inappropriate care conditions.

Essentially, Greek psychiatric reform took place when in 1986 the EU decided to fund Greek and foreign organizations to close down “Leros” and to launch the deinstitutionalization process and community based services. The implementation of an extensive transformation became possible through the “Psychargos” program, a national strategic and operational plan, which was developed by the Ministry of Health and Social Solidarity. The Psychargos program was jointly funded by the European Union by 75% of the cost over a period of 5 years and the Greek State. After the period of 5 years, the entire cost of the new services became the responsibility of the Greek National Budget. Over the years the Psychargos program became almost synonymous with the deinstitutionalization of long term psychiatric patients with the development of a wide range of community mental health services. The Psychargos program ended in December 2009 (Loukidou, Mastroyiannakis, Power et al, 2013).

Mental health care was traditionally provided in Greece by 9 large psychiatric hospitals. In 2008, three of them had closed and had been replaced by community residential facilities offering varying degrees of care, according to need. There are now 22 psychiatric departments (with beds) in general hospitals for adults, and 4 for children, with a further 13 hospitals having liaison and outpatient facilities. There are also 35 Mental Health Centers and 10 Child guidance clinics (Altanis, Economou, Geitona, et al., 2008).

The implementation of Psychiatric Reform in Greece began on the basis of the legislation concerning the National Health System (Law No. 1397/83), within the framework of Regulation 815/84 (European Community Program which laid the foundations for Psychiatric Reform). The 1983 law was expanded through Law No. 2071/92 and consolidated through Law No. 2716/99 “Development and Modernization of Health Services and other provisions”.

The first systematic effort for the implementation of a deinstitutionalization program took place within the framework of the implementation of the 1st Phase (1997-2001) of “PSYCHARGOS” national program.

PSYCHARGOS consists of two parts:

Programming of actions for the deinstitutionalization of patients from psychiatric hospitals, to return to smaller infrastructures (hostels or protected apartments) to their regions of origin (residence before being admitted to the psychiatric hospital).

Community-based structures to cover all the needs of the Mental Health Sector, in the form of a regional action specified at the level of prefectures and sectors.

There are sub programs designed according the needs of specific population:

for patients with mental disorders

for patients to autism's spectrum

for patients addicted to substances

for persons suffering from mental disorders and belonging to various
cultural and religious backgrounds

During the implementation of this phase, approximately 1,000 patients were relocated to modern structures providing mental health services. Significant experience and know-how has been acquired from these actions.

However, the limited implementation of the deinstitutionalization program, combined with the existence of social stereotypes and medical practices favoring of the model of closed institutionalized care, has created a resistance and impeded the progress of psychiatric reform. Time after time society and perhaps most professionals in the sector of Mental Health have not been really interested in reform after the reduction of EU funding.

The problem is also intensified by the fact that existing primary and secondary community mental health care structures are not adequate to meet increasing needs, which results in many patients being admitted to closed psychiatric structures.

At the same time, the number of personnel employed in the mental health sector is not sufficient to support the deinstitutionalization effort. Moreover, the existing infrastructure of certain psychiatric hospitals is old with a negative impact on patients' living conditions.

Provision of Mental Health Services	1980	2000
Chronic inpatients in public psychiatric hospitals (beds available)	5,677	2,922
Psychiatric wards in General Hospitals (beds)	16	361
Mental Health Centres	6	28
Medical-Pedagogical Centres	8	36
Day Centres/ Workshops/ Cooperatives/ Hostels/ Boarding houses	40	4,317

The borders, territory and seat of each Mental Health Sector have been determined by ministerial decision. Specifically, Mental Health Sectors have been established in every prefecture or broader region, while in Attica and in

the Prefecture of Thessaloniki, more than one Sector have been established, along with Mental Health Sectors for Children and Adolescents (CAMHS).

The model of sectorized organization of mental health services is aligned with the **British Mental Health model**, as created through the National Service Framework for Mental Health. In **Great Britain**, the planned health model related to the modernization of all health and social services and will serve as an organizational model for Greece.

With regard to Mental Health, this model adopts a program for the modernization of the organization of mental health services, which establishes national criteria for the promotion of new treatments, the creation of deinstitutionalization structures, the closing of psychiatric hospitals and the implementation of innovations and methods to evaluate the effectiveness of the model itself in the Mental Health sector throughout the country.

Results expected from the program are the following:

“Inclusion of everyone involved in mental health, patients and mental health professionals, in the planning and provision of services.

Provision of high quality care and treatment, which will be effective and appropriate.

Accountability of everyone involved in Mental Health.”

More specifically:

A. Gradual achievement of full sufficiency of all Mental Health sector services, regarding the population covered.

B. Reduction of the capacity of the Attica Psychiatric Hospital (to 500 beds) and of «Dromokaitio» Psychiatric Hospital of Attica (to 350 beds) by 2006 and their further downsizing by 2010.

C. Abolition of the Children’s Psychiatric Hospital of Attica by 2006 and its replacement, with regard to the provision of psychiatric services, by the General Hospitals of Attica.

D. Deinstitutionalization of all chronic patients originating from the area who are hospitalized in the country’s psychiatric hospitals.

E. Reduction of average hospitalization time in psychiatric wards by 20 %.

F. Guaranteeing patients’ rights.

G. Raising community awareness and mobilization of local communities into volunteer actions.

H. Securing employment for 30% of patients capable of working until 2005 and increasing this figure to 55% by 2010.

I. Relieving the needs of (an estimated) 40% of individuals with autism and their families by 2010.

J. Meeting the needs for health support of 40% of drug users and 60% of alcoholics (estimated data) by 2010”.

Until the end of 2001, the largest part of the PSYCHARGOS Program focused on the deinstitutionalization of patients. The program began with the operation

of 15 hostels and 120 sheltered apartments for the deinstitutionalization of 470 mentally ill persons. To date, 66 hostels, 14 boarding houses and 10 apartments have been created, hosting approximately 1,000 patients from all the psychiatric hospitals of the country, along with 1 boarding house for autistic persons, 1 hostel for mentally ill refugees and 35 training workshops for the mentally ill. Furthermore, 1,200 persons were hired for these structures (young Mental Health professionals) and were trained through special education programs.

The present Action Plan focuses on actions/projects that will be implemented during the 2nd phase of the Program, i.e. during the 2002-2006 period, at the end of which, the second revision of the Program (for the 2006-2015 period) is scheduled to take place.

(Data extracted from the official written declaration of the ministry of health 130342/25-11-2011 (ΦΕΚ 2741/Β/2011))

In November of 2011 till March of 2012, new proposals of the review committee were submitted and the decision about the new Psychargos was approved and published. The aim of this project is the ongoing evaluation of the National Action Plan of the Psychiatric Reform “Psychargos C 2011-2015” and the support of the relative authority in the decision making process.

The National Action Plan Psychargos C is a useful, visionary and strategic reference framework for the next period, but it lacks a comprehensive business plan.

Psychargos C, the new Andor-Lykourentzos Memorandum and the associated action plan, set up a framework for the Mental Health policy of Greece during the decade 2010-2020.

More specifically the project includes the following:

- “1. Evaluation of the overall policy and the Strategic Planning of the Psychiatric Reform
2. Evaluation of the applications and the implementation of the Psychiatric Reform
3. Evaluation of the management of the Psychiatric Reform

2. EVALUATION OF GREEK MENTAL HEALTH REFORM PROGRAM

“PSYCHARGOS”

EVALUATION MECHANISMS

Ex-ante evaluation

Ex-ante evaluation is the responsibility of the authorities entrusted with the drafting of plans, interventions and programming complements. It is carried out at the level of plans and programs, including programming complements, and involves.

Mid-term evaluation

Its objective is essentially to make any necessary adjustments, and to offer information for assessment of the performance of the various interventions.

The evaluation is carried out at the responsibility of the Managing Authority, in cooperation with the MH. Managing Authority and the European Commission are within the framework of the partnership.

The evaluation is carried out by an independent evaluator and submitted to the Monitoring Committee before being forwarded to the European Commission. It is up to the member state to decide whether, for its own reasons and to meet its own needs, it will conduct additional evaluations beyond the two mandated by the Regulation and mentioned above (mid-term and first report.)

Ex-post evaluation

The ex-post evaluation pertains to the interventions and is the responsibility of the Commission in cooperation with the member state and Managing Authority. It is intended to analyze the use of resources, the efficacy and performance of the interventions, their impacts and their usefulness and duration.

Again, the evaluation is carried out by independent evaluators and must be completed no later than three years from the end of the programming period

A retrospective evaluation, known in the management terminology as “ex-post evaluation”, of the implementation of the “National Action Plan Psychargos 2000-2010” of the psychiatric reforms was commissioned at the end of 2010 by the Greek Ministry of Health at the request of the European Union. The evaluation team consisted of independent assessors from abroad who had not been involved in the planning and the implementation of the Psychargos program and who were assisted by an expert greek team.

From the following PP we can extract data which focused on three main weak domains:

- Lack of treatment protocols and clinical guidelines
- User satisfaction
- Weaknesses in continuity of care within the catchment area

The Evaluation Team



- Greek and UK experts in the field of mental health
- Academic and health sector experts



- Ex post evaluation for the period 2001-2009
- On going evaluation for the period 2010-2015

The historical evolution of Psychargos

<u>Contributing factors</u>	<u>National Legislative basis</u>
1. The deficiency of the existing services.	1. regulation 815
2. The radical changes of psychiatric care the 1970s	2. Mental Health Act (Law 2716/1999) = 'Psychargos' Programme (A and B phases)
3. Leros psychiatric hospital case	3. 'Psychargos' Phase C (2010-2020)

Dimensions of the Evaluation

3 Dimensions

Criteria:

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Policy evaluation 2. Implementation evaluation 3. Evaluation of managerial processes for reform | <ol style="list-style-type: none"> 1. Consistency, logic, timeliness 2. Outcomes, results and impact 3. Administrative structure and management/monitoring Indicators |
|--|--|

Table 1 Planned and actually developed mental health units

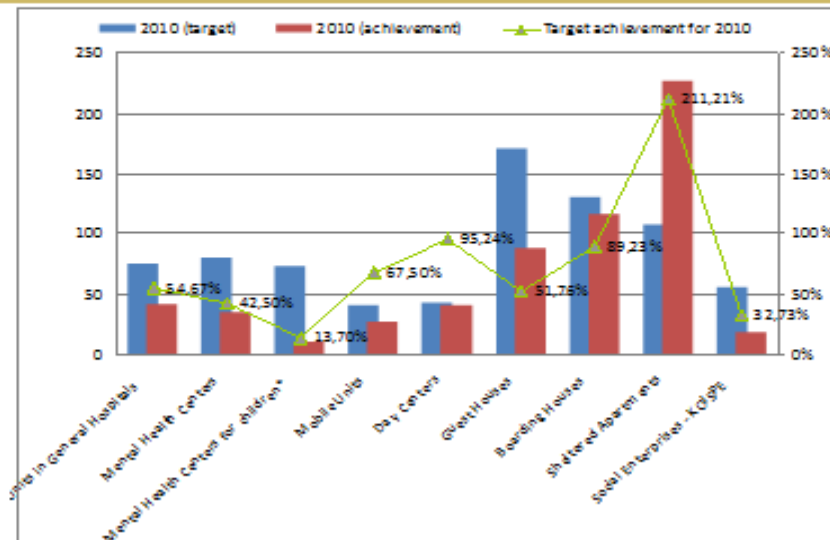
Mental health units	2001 (baseline)	2010 (target)	2010 (achievement)	Target achievement 2001-2010	
				Number	%
Psychiatric Hospitals*	9	4	3	-1	125
Psychiatric & Child-Psychiatric Units of General Hospitals		75	41	-34	55
Psychiatric Units of General Hospitals			30		
Child-Psychiatric Units of General Hospitals**			11		
Mental Health Centers	28	80	34	-46	43
Mental Health Centers for children ***	22	73	10		
Mobile Units	6	40	27	-13	68
Day Centers	18	42	40	-2	95
Psychosocial Rehabilitation Units	196	407	430	23	106
Guest Houses	95	170	88	-82	52
Boarding Houses	16	130	116	-14	89
Sheltered Apartments	85	107	226	121	211
Socio-vocational rehabilitation units	102	148	102	-46	69
Alzheimer's Centers		5	9	4	180
Drug abuse Centers		35	0	-35	0,00
Alcohol abuse Centers		15	0	-15	0,00
Social Enterprises -KOSPE		55	18	-37	33
Home Care Unit		✓	1	1	
Autism Center for children		✓	2	2	

*Includes Psychiatric Hospitals in full operation. Additionally the University Psychiatric Hospital "Aiginition" operates but does not have long-stay units.

** It is not reported in the First Revision of Psychargos (Ministry of Health & Social Solidarity 2001) neither the baseline number in 2001 nor the target-number for the development of Child-Psychiatric Units in General Hospitals. Therefore the success rate cannot be deduced.

***According to the First Revision of Psychargos (Ministry of Health & Social Solidarity 2001) the mental health centers for children were 22 in 2001. However, according to data provided by the Mental Health Directorate, in 2010 there were only 10 centers (mental health centers for adults that also provide services for children have not been included). Therefore the success rate cannot be deduced.

Mental Health Services



From an evaluation review of “Psychargos” program by Loukidou, Mastrogiannakis, Power, et al in 2012 we summarize: “the strategies of the Psychargos program have not been fully embraced by mental health professionals. The resettlement to community care with independent living has not been fully achieved. Training has not gone far enough due to staff shortages and lack of skills and knowledge, particularly for community care, rehabilitation and recovery. More preparation was needed, as changes were introduced very fast. Reforms started from tertiary care instead of primary care. There is no coordination of services”.

Services: "Lack of integration of services networks. A lot of emphasis was given to develop residential services and supported housing. There is a lack of services for children and adolescents. Several of the actions have been incomplete. There are major gaps in trained and experienced staff. Important service gaps were described for child and adolescents as well as other specialist mental health services. There is very little interaction among the different components of the services and from a service user and carer point of view this means lack of information about locally available services and poor information flow between different services. There are no quality assurance mechanisms (Evaluation team)”.

As Lora and Barbato report, there are evaluations’ studies about specific components of mental health, but it is rare to find studies evaluating an entire National Mental Health (Lora, Barbato, Cerati, et al., 2012).

A few studies have been conducted in the Greek context concerning the evaluation of deinstitutionalization and rehabilitation intervention projects implemented at Leros (Stylianidis, Gkionakis, 1997; Stylianidis, 1992; Tsiantis

et al., 2000) as well as the evaluation of specific rehabilitation programs (Tomaras et al, 1992).

Stylianidis and al state that it seems that the specific interventions developed in the community residential homes (focused on social skills training, psychosocial rehabilitation and achievement of a more independent way of living) have positive impact in many domains of social function, even for chronic psychiatric patients, who have spent a significant part of their lives in a psychiatric hospital. The results are in accordance with other studies conducted in the domain abroad. Although, in many cases the expectations of the staff seemed to be low from the beginning of the intervention and there were resistances, it seems that the significant improvements in the rehabilitation status of the patients provided important positive feedback for the staff (Stylianidis, Pantelidou, Chondros, 2008). Staff's evaluations about patients' readiness to be deinstitutionalized and their opinions for ideal future community structures for them seem to be positive objective as they are not influenced by patients' or relatives' views. (Giaglis, Michailidou, Angelidis, 2006). The general finding for staff's satisfaction in deinstitutionalization services is that job satisfaction of mental health workers in psychosocial rehabilitation structures in Greece should be improved in almost all parameters. Satisfaction in mental health professionals in "Psychargos" program is lower than in the general population. Generally employees in rehabilitation units suffer many years from huge delays in their payments and this occurs partly because the government took over the funding of reform and partly from the mismanagement of finances by the stakeholders.

An analysis performed in 2012 led to the study of six factors of professional gratification that deal with the prospect of the employees' advancement regarding the characteristics of work, the working environment, the relations among the colleagues, the participation in decision-making, and the potential of assuming initiatives. It has been concluded that the institution of employment, the type of structure as well as the years of previous working experience contribute greatly to the professional gratification. It has been indicated that the level of professional satisfaction of employees is very low possibly bias to financial recession which provokes huge problems to the implementation of "Psychargos" program (Markaki Athina 2013)

All of Psychargos targets are partly fulfilled. The emphasis was given to residential services for the deinstitutionalization of chronic patients and outpatient services were established unevenly.

In some cases, targets had not been achieved at all (crisis management centers for drug and alcohol abuse) (Loukidou, Mastroyannakis, Power, et al., 2013)

It is interesting that the opening remarks of the Assessment Report during (on going) the implementation of the National Action Plan "PSYCHARGOS" from 2011 to 2015 state: "The situation is the same as presented in the previous evaluation period (until 31/12/2011). Small differences have been made, but they are not implementing the operational planning.

As stated in the report, which took place early August 2014, although it is a common perception in Europe that the integration of people with mental disorders in society has significant benefits for the future of a country in

relation to their long-term hospitalization, few countries have taken steps in that direction.

Among them is certainly not Greece which is at the bottom in all the tables associated with the field of Mental Health. The assessment of countries was based on the Integration of Mental Health Index, which reflects the level of effort made by each country for integration into society of persons suffering from mental disorders. Top ten in the overall ranking list is Germany, Britain, Denmark, Norway, Luxembourg, Sweden, the Netherlands, Estonia, Slovenia and Belgium. Under Greece are only Romania and Bulgaria.

3. CHILD-ADOLESCENT OUTPATIENT MENTAL HEALTH SERVICES (CAMHS) IN GREECE

Child-Adolescent mental health services (CAMHS) in Greece was founded in 1984 according to the 815 law of deinstitutionalization. Unfortunately till today the majority of services are concentrated in the urban areas and 20 out of 54 prefectures of Greece are without services at all, while the rest of them occupy less staff than is required (Tsiantis 2008).

Greece lacks appropriate policies for children/adolescent mental health. Consequently, services do not constitute part of a system, and therefore they are not obliged to meet any kind of standards or have a structured accreditation.

The national budget for Child and Adolescent Mental Health does not compose a separate budget, but is part of the overall Mental Health budget. The Government provides less funding for Mental Health compared with General Health and, in fact, there is an even smaller amount of funding available for Child and Adolescent Mental Health (Tsiantis, Asimopoulos 2008).

According to the last review of pr.Tsiantis and al 2010 we know that:

“Prevalence of mental disorders in children and adolescents

No reliable data on prevalence is available at the regional or national level. The Ministry of Health and Social Solidarity is in the process of conducting an epidemiological study and collect prevalence data on Mental Health.

Vulnerable child population

It has been estimated that 20.5% of children in Greece are living in poverty and 5,800 children are homeless. Numbers have increased with the recession. About 13% of children are early school leavers (leaving school between the ages of 6 to 17 years old). Between 15% and 25% of school children have experienced bullying in school. According to data provided by the Ministry of Justice in 2007, 447 children were in detention.

Positive child and adolescent Mental Health

There is no available data on positive child and adolescent health in Greece.

Training of professional workforce

Child psychiatry is recognized as an independent field from general adult psychiatry in Greece. The training in Child Psychiatry for trainees and specialized doctors includes both theoretical and practical aspects.

The practical training aims to give trainees experience in child psychiatric diagnosis, in therapeutic treatment and in bio-psycho-social intervention for children and adolescents. Unfortunately, there is no training in CAMH promotion and prevention issues. We know that delays in the establishment of new CAMH departments in the general hospitals create additional difficulties

in the training of Child Psychiatry trainees (Braddick, Carral, Jenkins, et al., 2009)".

Greece services have undergone cuts (of nearly 50%) in funding between 2007 and 2008. This has resulted in a regression of care provided, especially child-adolescent, through community and a return to institutionalization.

The major cut in funding, threatens many current services with closure. Some of these services (day centers, hostels for adolescents with Mental Health difficulties, services for autistic children etc.) are being pioneered in Greece and now many of them have suspended their operation.

Apart from the funding cuts mentioned above, there is also a lack of collaboration and co-ordination between ministries, government organizations, and NGOs, which is a major issue too.

Despite the fact that CAMHS are gradually losing their first-established quality, the Greek Ministry of Health continues declarations such as:

The new revised program PSYCHARGOS C for mental health reform in Greece for the years 20011-2020 declares for children/adolescents mental health that mental health care for children and adolescents is an obligation of the state, because it is crucial investment for the future of the next generations. Thus, in the current phase the 'PSYCHARGOS' must guarantee that:

Priorities for development Child Psychiatry and better services of care.

1. Create at least one Children's Psychiatric Division enabled of hospitalization by Region.
2. Development of child guidance centers or day centers for children / adolescents as a priority in the major urban centers. Additionally, development Psychiatrists Services in community structures (Centers Mental Health or health centers) or outpatient General Hospital in each prefecture of the country and complete the staffing of Mobile Units with child psychiatry services.
3. Create specialized psychiatric services in Athens -Thessaloniki for children with mentally ill parents in Athens –Thessaloniki.
4. Create specialized psychiatric services in Athens -Thessaloniki for adolescents with anorexia nervosa.
5. Creation of specialized child psychiatrist services in Athens -Thessaloniki for children-adolescents who are refugees-immigrants.
6. Organization structures to meet the growing needs of abused-neglected children and links with the corresponding welfare facilities for children-adolescents.
7. Cooperation with the Ministry of Justice to review the status of Child Psychiatry Expertise and development structures adolescents with delinquent behavior.
8. Increasing specialization time in 5 years (proposal submitted Child Psychiatry Society in Greece) with configuration education content according to its Guidelines UEMS.
9. Development of the Academic Child Psychiatry (only 9 academic professionals).

10. Development of research on mental health of children and teen.
11. Evaluation of the quality and effectiveness of services provided by CAMHS.
12. Development of the institution of foster families and Utilization for the removal of institutional care (supplemental operation with hostels and other structures)
13. Exercise of child psychiatry in accordance with the principles of the Code Ethics of Child Psychiatry Association of Greece – Union Psychiatrists Children and Adolescents (2009), (www.hscap.gr).
14. Increasing the number of posts specialization from 40 to 70 (waiting time for specialization 8 -10 years)
15. Connection CAMHS with schools aimed at promoting mental health and integration of children.

(Data extracted from the official written declaration of the ministry of health Katsikarou-Bolaris 130342/25-11-2011 (ΦΕΚ 2741/Β/2011) 03 /05/2012

4. MENTAL HEALTH SERVICES AND FINANCIAL CRISIS IN GREECE

From Ancient Greek *κρίσις* (krísis, “a separating, power of distinguishing, decision, choice, election, judgment, dispute”), from *κρίνω* (krínō, “pick out, choose, decide, judge”)

Greece’s economic crisis started in 2009. The country has undergone its sixth consecutive year of economic recession. In 2013 its economy diminished by 20% and anemic or no growth was projected for 2014. Unemployment has more than tripled, from 7·7% in 2008 to 24·3% in 2012, and long-term unemployment reached 14·4%. The crisis has affected the health of the greek population and their access to public health services. Through a series of austerity measures, the public hospital budget was reduced by 26% between 2009 and 2011. Rural areas have particular difficulties, with shortages of medicines and medical equipment. Many patients must now pay up front and wait for subsequent reimbursement by the insurance fund. Pharmaceutical companies have reduced supplies because of unpaid bills and low profits.

Another concern is the reduction of health coverage. Social health-insurance coverage is linked to employment status. Rapidly increasing unemployment since 2009 is increasing the number of uninsured people.

We can only mention the current situation of Greek public health focusing mainly on short-term effects by reducing expenditure, while the measures imposed seem to have dubious long-term consequences for Greek public health and healthcare. (Kentikelenis, Karanikolos, Reeves, et al, 2014)

Mental health services have also been seriously affected.

Rapid socioeconomic change can harm mental health and no measure was taken to ameliorate the situation by appropriate social policies. The funding for mental health has been reduced dramatically after 2010.

From 2007 to 2009, increased violence rates, and nearly doubled homicide and theft rates were recorded. In addition, an association between major depression and economic crisis was found since in 2011 it was 2.6 times more likely for Greeks to be diagnosed with major depression compared to 2008. Suicides in Greece have increased by 17% from 2007 to 2009, with unofficial data mentioning a 25% increase in 2009–2010. The Ministry of Health reported in 2011 an increase in suicides by 40%.

Greece public and non-profit mental health service providers have reduced operations, shut down services, or fired staff. Plans for development of child psychiatric services have been abandoned and state funding for mental health decreased by a further 55% between 2011 and 2012. Austerity measures have constrained the capacity of mental health services to cope with the 120% increase in use in the past 3 years (EPHA Report p.11, 2014).

Greece’s austerity measures have mainly affected child health, in addition to reduced family income and unemployment of parents. The proportion of children at risk of poverty has increased from 2% in 2007 to 4% in 2011 and a growing number receive inadequate nutrition (UNICEF, 2013). A 2012 UN

report emphasized that “the right to health and access to health services is not respected for all children in Greece” (Kentikelenis, Karanikolos, Reeves, et al., 2014)

Some General Epidemics

The cuts in health budgets have influenced all crucial health domains and prevention health programs. The number of human immunodeficiency virus (HIV) infections has been continuously rising mainly due to the increasing numbers of injecting drug users affected also by abolition of preventive programs, with the number of cases of HIV infections in IDUs being 10–15 in 2007–2010, 256 in 2011, and 314 in the first 8 months of 2012. During 2009–2011 Greece experienced unevenly high morbidity and mortality burden of various large-scale epidemics: high mortality burden of pandemic influenza A (H1N1) in 2009, major out-break of West Nile Virus (WNV) infections in 2010 and 2011, outbreak of autochthonous *Plasmodium vivax* malaria in 2009–2011, and major HIV outbreak among IDUs in 2011.

Available data suggest a 19% increase in the number of low-birth weight babies between 2008 and 2010. 23 Researchers from the Greek National School of Public Health reported a 21% rise in stillbirths between 2008 and 2011, which they attributed to reduced access to prenatal health services for pregnant women. The situation in Greece has been characterized as “alarming” with indications that its health system could potentially collapse.

Greece is the country that has the highest rates in the EU on MRI units (22.6 per million population) and CT scanners (34.3 per million population), on MRI and CT exams (97.9 and 320.4 per 1000 population, respectively), and on the antibiotics ‘consumption (dose of 39 per 1000 population per day). In addition, poor information system allows repetition of prescriptions and tests, leading to high costs for the system. Greeks are not familiar with GPs and PHC is under-funded with a highly hospital-oriented healthcare system, despite WHO’s recommendations the past 30 years (Simou, & Koutsogeorgou, 2014).

Underfunding has been a threat to reformed services. Thornicroft et al report that there are not enough epidemiological evidence to show service development especially when they are under a status of funding reduction (Christodoulou et al, 2012)(Thornicroft et al, 2011).

A report from the European Public Health Alliance (EPHA) in November 2014 highlights existing evidence on the detrimental effect of the ongoing economic crisis and austerity-driven measures on the mental health and well-being outcomes of the European child and adolescent population.

Evidence has been collected at an increasing rate and shows shocking levels of childhood poverty. According to the recent report by UNICEF “Children of the Recession: The impact of the economic crisis on child well-being in rich countries”, went up from 2.6 million since 2008, to 76.5 million children living in poverty in rich countries. From 2007 to 2013, feelings of insecurity and stress rose in 18 of the 41 countries studied, according to measurable self-perception indicators (including access to food and satisfaction with life).

Some 1.6 million more children were living in severe material deprivation in 2012 (11.1 million) than in 2008 (9.5 million) in 30 European countries.

Poverty is one of the greater threats to children's well-being, its physical, mental and social adaptation. Prolonged exposure to material poverty, social exclusion and discrimination in early years can have a damaging effect on mental well-being, health outcomes and future opportunities

It is estimated that 7.5 million young people aged between 15 and 24 years old (roughly equivalent to the population of Switzerland) were "Not in employment, education or training" across the EU in 2013 (EPHA Report 2014).

Among other things, poor mental health in childhood is associated with other health problems in young adulthood (e.g., substance abuse, violence, less educational progress, poor reproductive and sexual life), while higher rates of psychiatric disorders in adulthood are associated with multiple disadvantages during childhood (e.g., loss of parents through break-ups, financial hardship, mental disorder in parent) (Harper G. 2012). Children are a vulnerable population group and strong evidence exists on the link between socioeconomic living conditions and child health (Rajmil, De Sanmamed, Choonara, et al., 2014). The literature on previous recessions in different countries and periods suggest that exposure to poverty in early life and during childhood for prolonged periods may have a strong and irreversible impact on physical, cognitive and social health of the childhood population (Lundberg 2012).

More specifically in Greece, the ex-post evaluation of the National Action Plan Psychargos, which covered the period of 2000–2009, showed that only 30 % of the planned services for children have actually been created. Furthermore, a large number of community centers, psychosocial rehabilitation units, and highly specialized establishments have suspended their operation. The impact was particularly severe for units dealing with special categories of disorders, such as pervasive developmental disorders and learning disabilities. Typical examples of the situation are the following: (a) in the city of Piraeus, all community CAMHS (n = 6) have suspended their activity, (b) the Hellenic Centre for Mental Health and Research (1956), which is the largest and most comprehensive outpatient institution and the first community psychiatric service for children and adolescents in Greece, was forced to merge its services in Attica, to cancel deinstitutionalization programs, and to shut down accommodation units for deinstitutionalized patients, while it is also planning to suspend branch operations outside Attica, (c) the Sikiarideio Foundation (1941), which is the oldest institution for mentally disabled children, has suspended all services and (d) the Perivolaki (1983), a leading institution for autistic child-care, has shut down two of its units. The existing National Healthcare System of CAMHS now operates with 10–40 % fewer employees, who are not paid regularly and whose salaries have been cut by 40%. A large portion of the more experienced personnel has been forced to move abroad. At the same time, the number of new cases has increased, and the demand for supportive work within the community (due to the collapse of social services) and schools (due to insufficient psychological services) has also increased. Furthermore, an increasing number of patients are leaving the

private sector to seek care within the public system. A recent survey in a representative sample of both public and private child psychiatric institutions in Athens, Piraeus, and Thessaloniki compared data from 2007 and 2011 (two years before and two years after the implementation of austerity measures) revealed a 39.8 % increase in new cases in public outpatient services for children and 25.5 % for adolescents, while percentages have dropped by a total of 35.4 % in the private sector between the years 2007 and 2011. As a result, both the waiting list and waiting time are now longer. In most CAMHS, the waiting time for ordinary cases has tripled (Kentikelenis, Karanikolos, Papanicolas, et al., 2011)

Equally severe is the impact of the crisis on schools, which are being constantly undermined and devalued, both at a material level, with the lack of necessary funding and its consequences on school operation (Hainsworth, 2011).

Findings from surveys showed that cases of psycho-social problems have risen by 40%, cases of conduct disorders have risen by 28%, cases of suicide attempts have risen by 20 %, cases of school refusal have risen by 25 %, cases of bullying have risen by 22 %, cases of the use of illegal addictive substances have risen by 19 %, and cases of family discord have risen by 51% (due to parental unemployment, serious financial problems, and exorbitant debts). Data from adolescent inpatient units showed an admission increase of up to 84 %, with diagnoses on admission of borderline conditions, severe behavioral disorders, acute psychotic crises, self-harm behaviors, and other similar conditions constituting 78 % of the total cases in 2011, compared to only 48 % in 2007. Borderline states are now more common, and generalized substance abuse has spread throughout the majority of schools, along with bullying and racist behaviors (Anagnostopoulos, Soumaki 2013).

At the same time, an increasing number of children removed by court order from their families arrive at the Children's Hospital "Agia Sophia" (less than 20 per year before 2010, 81 in 2010-11, 92 in 2011-12, 141 2012-13, 157 the period 2013-14!), primarily for reasons of socioeconomic. From these, only 30% return to their families (Kolaitis, Fissas, Christogiorgos, et al., 2010).

Taking advantage of Greece's culture

Greek society has traditionally depended on local communities and family for mental healthcare. Unfortunately family is itself in crisis at the moment, due to unemployment or poverty. Communities and the Church try to take care of a part of the vulnerable population and they are often a shelter when mental illness emerges (Christodoulou, & Anagnostopoulos, 2013).

Organization of outpatient CAMHS

“The development of appropriate child and adolescent mental health services is a challenge, even in the most developed countries. However, the extent to which this challenge is met depends not only on the resources available within the country, but also on creativity and the will to enhance local strengths, pool resources and emphasize a commitment to the mainstreaming of children and adolescents with mental disorders in community settings” (WHO 2005).

Service organization should be based on the principles of:

- Availability
- Accessibility
- Acceptability
- Integration
- Sectorization
- Continuity of care
- Comprehensiveness
- Evidence-based
- Respect for human rights

J.M Caldas "Organization of mental health services." Lisbon 2014

Thornicroft and Tansella 1999, state that the process of deinstitutionalization in the last three decades has led to a reduction in the numbers of patients in mental hospitals. However, the deinstitutionalization process has not been accompanied by a sufficient provision of community-based residential and occupational facilities. Although deinstitutionalization research in North American and Western European countries proves the better quality and lower cost of provision of care by community mental health services, these services are often inadequate and unevenly distributed nationally (Thornicroft, Tansella, 2006).

For children and adolescent the process of deinstitutionalization and the developing of outpatient-community based services are more complicated than the adults' ones.

First of all the results of recent epidemiological studies have illustrated the need for further development of the psychiatric diagnostic system. There is growing dissatisfaction with the current categorical diagnostic system, which is not believed to provide a valid representation of emotional and behavior problems in youth. First, there is research demonstrating that some diagnostic entities are better characterized as a spectrum. French diagnostic criteria are far away from US ones. For example, specialists from the US, Germany and the Netherland have begun to expand the diagnostic concept of bipolar disorder in children and adolescents. In the National Comorbidity Survey-Replication (NCS-R) demonstrated the clinical significance of the spectrum concept of bipolarity that had long been described in clinical settings. Also

epidemiologic studies of children show that there is pervasive comorbidity between purportedly distinct diagnostic entities. Generally few children manifest only a single disorder. For French-speaking specialists and a number of British there is another opinion about the diagnostic categories of adults which are expanded to children. They use more the developing perspective for the symptoms of a child and they assess children with a holistic point of view regarding brain plasticity and the facilitate environment of a child.

Obviously, if the diagnostic criteria for children are a controversial field, the services for children and adolescents would be also a field with different opinions concerning domains as care and intervention.

With the exception of pervasive developmental disorders, there has been considerable controversy about the validity of diagnosis of mental disorders in very young children (ages 2 to 5 years). Logger and colleagues reported that there is accumulating evidence that mental disorders generally identified in school-age children are quite prevalent in preschool children. He gives a summary of the community surveys of young children with the following range of rates of childhood disorders: ADHD from 2% to 5.7%; ODD from 4% to 16.8%; CD from 0% to 4.6%; depression from 0% to 2.1 %; and anxiety disorders from 0.3% up to 9.4%. In addition to the prevalence of these disorders in young children, rates of impairment are very high (i.e., about 84.6% of those with emotional disorders and 100% of those with behavioral disorders). There is also a high degree of comorbidity in young children with mental disorders, of those with one disorder, approximately 25% have a second disorder. The proportion of children with comorbidity increases about 1.6 times for each additional year from age 2 (18.2%) to 5 (49.7%). We can understand that if specialists don't agree about the age of the onset of mental illness in children and the types of intervention, the planning and function of services would be a controversy issue too. Specialists of non US point of view don't "measure" psychopathology with the same way, so we cannot compare the evidences.

Nevertheless, action to reduce mental illness among children would produce major savings to society and the best way of DALY's reduction.

Leibson showed that over a nine year period the median medical costs for children with ADHD were \$4,306.00 compared with \$1,944.00 for children without ADHD (Leibson, Katusic, Barbaresi, et al., 2001),. The costs are due to higher rates of admission to hospital emergency and outpatient departments and visits to primary care physicians. The study excluded the costs of treatment by psychiatrists and mental health professionals (Leibson, Katusic, Barbaresi, et al 2001).

Expenditures for children's mental health services in US were nearly \$11.75 billion in 1998—a three-fold increase from 1986. Outpatient care accounts for a significant proportion of mental health expenditures for children and youth (nearly 60%) followed by inpatient care (about 33%). It is suspected that a significant proportion of these outpatient costs are attributable to school-related services by mental health professionals. Use of psychotropic medications in youth has increased; more than \$1 billion was spent in 1998 on psychotropic medications for children ages 6 to 17. Pharmacy benefits manager Medco Health Solutions reported a 77% increase between 2000 and

2003 in spending on behavioral medications for the group of 300,000 children and youth under age 19 whom it studied (NIHCM February 2015).

Research suggests that many mental health disorders in children, before they reach the medication stage, might be prevented or ameliorated with prevention and early detection. Overall, prevention and early intervention efforts targeted to children, youth and their families have been shown to be beneficial, cost-effective and reduce the need for more costly interventions such as welfare dependency and juvenile detention. Indeed, early intervention efforts can improve relationship of family, school readiness, health status, and academic achievement. Mental health services and counseling centers in the “entry points” of children and adolescent, for example in pediatric, primary school, high school, university, athletic activities, social services, could be a solution for youth wellbeing.

The economic logic for CAMHS is simple: treating mental illness can be expensive, but leaving mental illness untreated is more expensive and many nations cannot afford it.

We need services to cover ages from 0 to 23 year old in child-adolescent psychiatry. Early relationships are critical because the brain’s plasticity is highest in young children who are more vulnerable to bad influences and more receptive to good ones. There are brain differences between groups of people who have and have not been maltreated as children. Attachment is one of the factors of emotional capacity. The growth flood in adolescence is another period of change and development. A life-course approach is based on the recognition that adult health and illness are rooted in health and experiences in previous stages of life and it reflects social, environmental, biomedical, economic and other relevant factors that influence health.

Summarizing, we can propose some guidelines for the organization of CAMHS extracted by the international literature and evidence-based research. First let’s leave the epidemiology guide by asking some questions:

a) How many children and adolescents in the community have mental health problems? b) How many children and adolescents make use of mental health services? c) What is the distribution of mental health problems and services across age, sex, and ethnic groups? d) Are there historical trends in the frequency of child and adolescent mental health problems? e) What is the developmental course of mental health problems from childhood into adulthood? f) What etiological factors can be identified to inform the design of prevention and treatment programs? g) How cost effective are child and adolescent mental health services? h) What are the outcomes for children and adolescents who received services? The answers to these questions can be used as a strong basis for planning and implementation of services (Merikangas, Nakamura, & Kessler, 2009).

Some general guidelines for CAMHS could be the following:

Information

More information in children's centers (athletic, occupational, camps etc.), schools, colleges and GP practices or pediatrics about mental health; how to promote it and how to deal sensitively with issues that arise.

Accessibility

Services in convenient places.

Information and advice available for the services.

Age-appropriate services.

Empathy

Being listened to and given individual attention, whichever service you are dealing with.

Being spoken to in a straightforward way, with no technical language

Clarity over confidentiality arrangements.

Support

Services available when the need first arises, not when things reach crisis point.

Services that stay in touch after support or treatment have finished and follow up any problems.

Holistic approach

Services think about patient as an individual; for example, providing help with practical issues and addressing physical health as well as mental health.

Free- Public Services

QUALITY ASSURANCE OF OUTPATIENT CAMHS

DEFINITIONS

Quality / The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine, 2001).

Standards / Normative qualitative statements about what constitutes acceptable and adequate mental health care (Lund et al., 1998).

Accreditation / is the authorization of a service that meets specified standards. Accreditation ensures that quality is not an optional extra for mental health services but an essential requirement for their legal functioning.

Until the late 1970s, quality assurance in the healthcare field was restricted to research conducted by academic institutions, in contrast to industry where statistical methods had already been in use since the 1930s.

Donabedian, in a review of papers published between 1954 and 1984, identified three supports for quality assurance in health care: “Sound structures, good processes and suitable outcomes. Quality in health care is associated with effectiveness, efficiency and technical competence, as well as safety, accessibility and a patient-centered approach, on the basis of continuity of service. Quality can be measured, and it involves all aspects of the functions of departments, from staffing and management to clinical practice. Quality cannot be achieved without evaluation of performance (Papakostidi, Tsoukalas, 2012).

Quality indicators for mental health services cannot assure the quality of the care provided but focus on fields that need improvements and confirm that the implemented measures were successful (Lazarou 2012)

In mental health care, quality is a measure of whether services promote a better life for patients. This means medical and social amelioration for patients and their families, while practitioners and policy makers work together using the current knowledge and technology (WHO 2003 quality of services).

Standards are a way of formally describing how a service should deliver care. In order to create effective services, countries should develop quality standards based on the international ones.

Accreditation is the official authorization of a mental health service by a public body that is legally entitled to fulfill this role. Accreditation therefore presents an opportunity to assess the quality of care delivered by a particular service and to provide the service with the appropriate legal recognition.

This protects people with mental disorders, mental health workers and funders by ensuring that care is of an acceptable standard. In this way, domains of services needing amelioration can be identified.

According to WHO guidance (2003) quality improvement for mental health, the steps taken for the quality of care provided by services should be:

Step 1: Align policy for quality improvement.

- Step 2: Design a standards document.
- Step 3: Establish accreditation procedures.
- Step 4: Monitor the mental health service by using the quality mechanisms.
- Step 5: Integrate quality improvement into the ongoing management and delivery of services.
- Step 6: Consider systematic reform for the improvement of services.
- Step 7: Review the quality mechanisms.

Drake et al 2001 insist that the implementation of evidence-based services should become a means of achieving both quality and accountability. For child-adolescent mental health services quality improvement should include the participation (where appropriate) of child and adolescent who is receiving services, as well as their families, in designing, implementing and evaluating services. Users 'satisfaction and outcome evaluation help services to ameliorate their delivery of care. It is therefore inevitable that a range of tools and quality criteria may be applicable to an individual service.

OBJECTIVES OF THE STUDY

Article 24 of Convention on the Rights of the Child states that: “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services” and Article 25 “States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement”.

Greece has ratified the “Convention on the Rights of the Child”. The Greek state has developed to a certain degree a number of services which protect and support the principles of Convention. Unfortunately the Greek state does not apply certain mechanisms of evaluation of these services and there are not specific standards which ensure the quality of child-adolescent services, especially in the domain of mental health (Tsiantis 2000)

Many countries, notably in US, Canada, Australia and UK, have created quality standards for CAMHS as evaluation of care delivered and they have guidelines under which services should work.

In Greece quality Assurance in Mental Health Services is performed only for the hospitals using the International Standardization ISO 9001: 2000, but no tool is used for the evaluation of outpatient services. (Ethimiou X. 2005)

The claims from consumers’ organizations and insurance companies have launched a series of procedures for the development of performance measurement systems for health care units.

Many of these measures do not compose a standardized methodology. The evaluation process most of the time comes from the goals and the interest of the stakeholders in health care provision (suppliers, paying bodies, patients, customers, etc.). For example, for patients, the evaluation criterion is the satisfaction of medical services. For doctors, quality assurance can be concerned as the achievement of desired clinical outcomes. Respectively, for managers, quality can be interpreted by the cost effectiveness of services.

(Gounaris 2006).

Measurement tools assessing mental health of children and adolescents have been available for many years. However, no review has considered whether and which of the tools would be suitable for use as outcome measures in routine clinical practice (Hunter, Higginson, Garralda, 1996).

Measurement tools which assess mental health services for children and adolescents are rare and the process of accreditation for CAMHS is not based on specific standards in the majority of countries. It is more common for the evaluation of services to be done by users’ satisfaction. The patient-family experience focuses on issues related to accessibility, humanity of care, organization of care, environment and outcomes (Attride-Stirling, 2003).

HONOSCA the version of HONOS for Children and Adolescents is a recently developed measure of outcome for use in CAMHS (Garratt, Bjertnaes, Holmboe et al, 2011).

In Greece, CAMHS don't have an evaluation process and research on users' satisfaction is rare. The Greek CAMH services accredited by the Ministry of Health don't rely on national standards for CAMHS in Greece, but on the general standards of psychiatric reform.

This study was conducted aiming for the fact that it is crucial to have evaluation mechanisms to audit the quality of services.

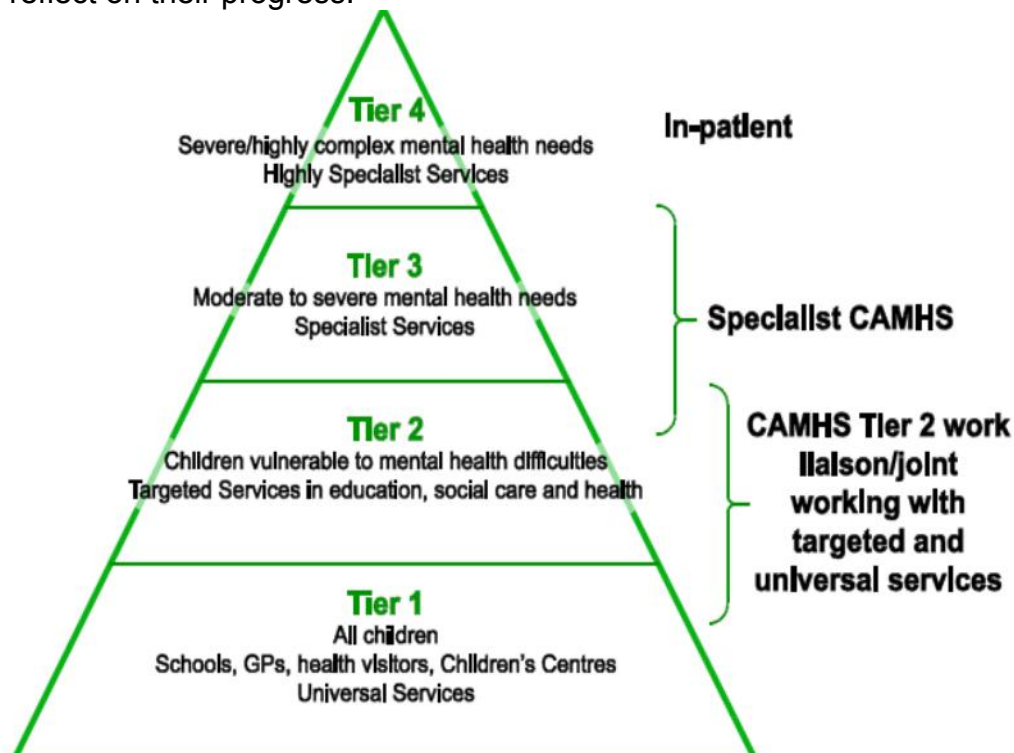
The objectives of the study are:

- To evaluate Greek outpatient CAMHS in the Attica region
- To apply for the first time a tool for evaluation in Greek outpatient CAMHS
- To translate and adapt the British tool in Greek reality
- To see in which degree the Greek outpatient CAMHS comply with the British standards
- To identify the strong and weak areas of Greek CAMHS
- To promote the evaluation process for mental health services in Greece

METHODS

For our study we use the self-review questionnaire of Quality Network for Community CAMHS (QNCC). QNMHS and Royal College of Psychiatry work with professionals from health, social services, education and the voluntary sector to improve the quality of CAMHS services throughout the UK.

The self-review provides a valuable opportunity to see how well the Tier 3 of CAMHS performing against the standards and allows the services as a team to reflect on their progress.



QUALITY NETWORK FOR COMMUNITY CAMHS

3rd Edition Standards (2012)

We chose the British tool for the following reasons:

1. The Greek model of services relay on the British model according to the reform law of mental health in Greece.
2. The British standards are recently (2012) revised and adapted to European culture.
3. The self-review tool of British standards is easily performed.
4. The standards assist to service organization and structure and prioritize developmental plans for the delivery of care.
5. The standards help clinicians to understand every element of the service they work in.

First, we had taken the written permission for using the tool by the British team of Quality Network for Community CAMHS.

Using the back translation method (Brislin, 1970), the CAMHS tool was translated and adapted into Greek by two independent bilingual official translators and was posted to outpatient CAMHS of Attica. All services were informed about the study aim via personal or written communication and the anonymous participation was noted.

Descriptive analysis was performed for all items and sub-scale categories.

The statistical analysis was performed with the Statistical Package for Social Sciences SPSS version 22 (IBM, 2013). In order to measure the internal consistency of CAMHS items/questions, a Cronbach's alpha was performed.

The study was conducted under the auspice of the Athens University of Economics and Business. No ethical approval was required from the patients of services, as the aim of the study was to examine how services perform against the standards and not their personal data.

Results

CAMHS British standards consist of 10 sections which are assessed in every mental health service and are shown in Appendix 1.

For the aim of the current study three of these sections were utilized, as more useful and compatible with the greek reality:

1) Referral and Access

2) Assessment & Care Planning

3) Care & Intervention.

The items of each section are presented in Appendices 2 to 4.

There are 12 sectors in the Attica region after the geographical territorial definition of 2002. In these sectors after the crisis there are twenty outpatient CAMH services still in function. Twelve out of the twenty responded to the study.

Data were collected and posted back to the distributor of the greek version.

Due to the multiple questions/items derived from CAMHS and translated into Greek an internal consistency measure was needed. Therefore a Cronbach's Alpha was conducted, in order to determine the reliability of the scale. A high internal consistency was indicated based on the 65 items tested (Cronbach's $\alpha=0.879$).

Each mental health team was asked to respond based on a four-point Likert scale ('no', 'partly', 'yes', 'do not know'-'not applicable'). The scoring range for each category was calculated based on the number of items on each subscale multiplied by the highest scoring value of two, which equals to "Yes". For example, if services comply 100% with the standards, the answers would be all the number 2 and the highest score would be the sum of the items of category multiplied by 2.

So the range for:

- "Referral and Access" was 0 till 32 (items 16 multiplied by 2),
- "Assessment & Care Planning" was 0 till 58 (items 29 multiplied by 2)
- "Care & Intervention" 0 till 40 (items 20 multiplied by 2).

Due to the small number of "do not know/not applicable", those values were treated as missing data and excluded from the analyses.

The Likert scale choices were then grouped into three likert responds (no, yes, partly) and the sum of each subscale items was computed as a new variable including all the items of "Referral and Access", "Assessment and Care Planning" and "Care and Intervention".

The validation of the three subscales' results compared to CAMHS standards was calculated based on the percent range of each sum score.

The total range of each sub scale was then split in three part and calculated based on the 0-24th, 25th-74th and 75th-100th percentiles. This provided the below, which were used for the validation of the CAMHS items into the Greek

mental health care for child-adolescent: 0%-24% (Not meeting the standards-low score of replies), 25%-74% (Moderately meeting the standards-moderate score) and 75%-100% (Meeting the standards-high score of replies).

Tables 1 to 3 include the number and percent of each reply based on the total number of services assessed.

The sum scores of each subscale placed most of the mental health services in the “partly” reply.

(Sum score of Referral and Access, range 0-32, mean 12.64, median 13, mode 13, std. 2.693).

Statistics

(D) ReferAccessSUM

N	Valid	11
	Missing	1
Mean		12.64
Median		13.00
Std. Deviation		2.693
Range		9
Minimum		9
Maximum		18

(D) ReferAccessSUM

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	9	1	8.3	9.1	9.1
	10	2	16.7	18.2	27.3
	11	1	8.3	9.1	36.4
	12	1	8.3	9.1	45.5
	13	3	25.0	27.3	72.7
	14	1	8.3	9.1	81.8
	16	1	8.3	9.1	90.9
	18	1	8.3	9.1	100.0
	Total	11	91.7	100.0	
Missing	System	1	8.3		
Total		12	100.0		

(Sum score of Assessment & Care Planning, range 0-58, mean 37.22, median 35, mode 35, std. 7.345)

Statistics

(D) Sum of scores Assessment and Care

N	Valid	9
	Missing	3
Mean		37.22
Median		35.00
Std. Deviation		7.345
Range		21
Minimum		28
Maximum		49

(D) Sum of scores Assessment and Care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	28	1	8.3	11.1	11.1
	29	1	8.3	11.1	22.2
	32	1	8.3	11.1	33.3
	35	2	16.7	22.2	55.6
	39	1	8.3	11.1	66.7
	42	1	8.3	11.1	77.8
	46	1	8.3	11.1	88.9
	49	1	8.3	11.1	100.0
	Total	9	75.0	100.0	
Missing	System	3	25.0		
Total		12	100.0		

(Sum score of Care & Intervention, range 0-40, mean 23.22, median 26, mode 28, std. 6.261).

Statistics

(D) Sum of scores Care and Intervention

N	Valid	9
	Missing	3
Mean		23.22
Median		26.00
Std. Deviation		6.261
Range		16
Minimum		14
Maximum		30

(D) Sum of scores Care and Intervention

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	14	1	8.3	11.1	11.1
	16	1	8.3	11.1	22.2
	17	1	8.3	11.1	33.3
	21	1	8.3	11.1	44.4
	26	1	8.3	11.1	55.6
	28	2	16.7	22.2	77.8
	29	1	8.3	11.1	88.9
	30	1	8.3	11.1	100.0
	Total	9	75.0	100.0	
Missing	System	3	25.0		
Total		12	100.0		

Figures 1-3 present the sum of scores for all three CAMHS sections.

Overall the grouping categories of the three CAMHS sections utilized in this study, proved to moderately meet the British standards with the exception of "Assessment and Care" section which proved to be above moderate/meeting the standards for two out of nine (22%) mental health services (Figure 4).

Table 1. Frequencies and percent of replies on Referral and Access items of CAMHS section 1.

Referral and access items	No		Partly		Yes	
	n	%	n	%	n	%
1.1.1	4	33.3	7	58.3	1	8.3
1.1.2	5	41.7	6	50.0	1	8.3
1.1.3	11	91.7	1	8.3	---	---
1.1.3a	10	83.3	1	8.3	1	8.3
1.1.3b	---	---	2	16.7	10	83.3
1.1.4	6	50.0	3	25.0	3	25.0
1.2.1	3	25.0	2	16.7	7	58.3
1.2.2	5	41.7	4	33.3	3	25.0
1.2.3	5	41.7	6	50.0	1	8.3
1.3.1	3	25.0	7	58.3	2	16.7
1.3.2	1	8.3	6	50.0	5	41.7
1.3.3	5	45.5	5	45.5	1	9.1
1.3.4	2	16.7	---	---	10	83.3
1.4.1	3	25.0	7	58.3	2	16.7

1.4.2	10	83.3	2	16.7	---	---
1.4.3	8	72.7	2	18.2	1	9.1

Table 2. Frequencies and percent of replies on Assessment and care planning items of CAMHS section 2.

Assessment and care planning items	No		Partly		Yes	
	n	%	n	%	n	%
2.1.1	1	8.3	7	58.3	4	33.3
2.1.2	1	8.3	4	33.3	7	58.3
2.2.1	---	---	10	83.3	2	16.7
2.2.2	4	16.7	5	41.7	3	25.0
2.2.3	---	---	2	16.7	10	83.3
2.3.1	4	83.3	3	25.0	5	41.7
2.4.1	---	---	1	8.3	11	91.7
2.4.2	1	9.1	5	45.5	5	45.5
2.4.3	1	8.3	8	66.7	3	25.0
2.4.4	2	16.7	6	50.0	4	33.3
2.4.5	1	8.3	1	8.3	10	83.3
2.4.6	6	50.0	4	33.3	2	16.7
2.5.1a	1	8.3	5	41.7	6	50.0
2.5.1b	---	---	1	8.3	11	91.7

2.5.1c	1	91.7	5	45.5	5	45.5
2.5.2a	1	8.3	2	16.7	9	75.0
2.5.2b	1	8.3	6	50.0	5	41.7
2.5.2c	1	8.3	5	41.7	6	50.0
2.5.2d	---	---	8	66.7	4	33.3
2.5.2e	3	25.0	6	50.0	3	25.0
2.5.4	2	16.7	3	25.0	7	58.3
2.6.1	6	50.0	5	41.7	1	8.3
2.6.2	1	8.3	9	75.0	2	16.7
2.6.3	---	---	3	25.0	9	75.0
2.6.4	---	---	1	8.3	11	91.7
2.6.5	7	58.3	4	33.3	1	8.3
2.6.6	3	27.3	4	36.4	4	36.4
2.7.1	4	33.3	8	66.7	---	---
2.7.2	5	41.7	6	50.0	1	8.3

Table 3. Frequencies and percent of replies on Care and Intervention items of CAMHS section 3.

Care and intervention items	No		Partly		Yes	
	n	%	n	%	n	%
3.1.1	---	---	3	25.0	9	75.0
3.1.3	---	---	5	41.7	7	58.3
3.1.4	3	25.0	4	33.3	5	41.7
3.2.1	3	25.0	5	41.7	4	33.3
3.2.2	2	16.7	7	58.3	3	25.0
3.3.1	4	33.3	4	33.3	4	33.3
3.3.2	3	27.3	4	36.4	4	36.4
3.3.3	5	41.7	5	41.7	2	16.7
3.4.1	---	---	4	33.3	8	66.7
3.4.2	---	---	8	66.7	4	33.3
3.4.3	---	---	---	---	12	100.0
3.4.4	1	10.0	6	60.0	3	30.0
3.4.5	7	58.3	3	25.0	2	16.7

3.5.1	5	41.7	4	33.3	3	25.0
3.5.3	---	---	9	75.0	3	25.0
3.5.4	1	8.3	4	33.3	7	58.3
3.5.5	9	75.0	3	25.0	---	---
3.6.1	7	58.3	3	25.0	2	16.7
3.6.2	12	100.0	---	---	---	---
3.6.3	7	58.3	5	41.7	---	---

Figure1. Sum of scores of Referral and Access section

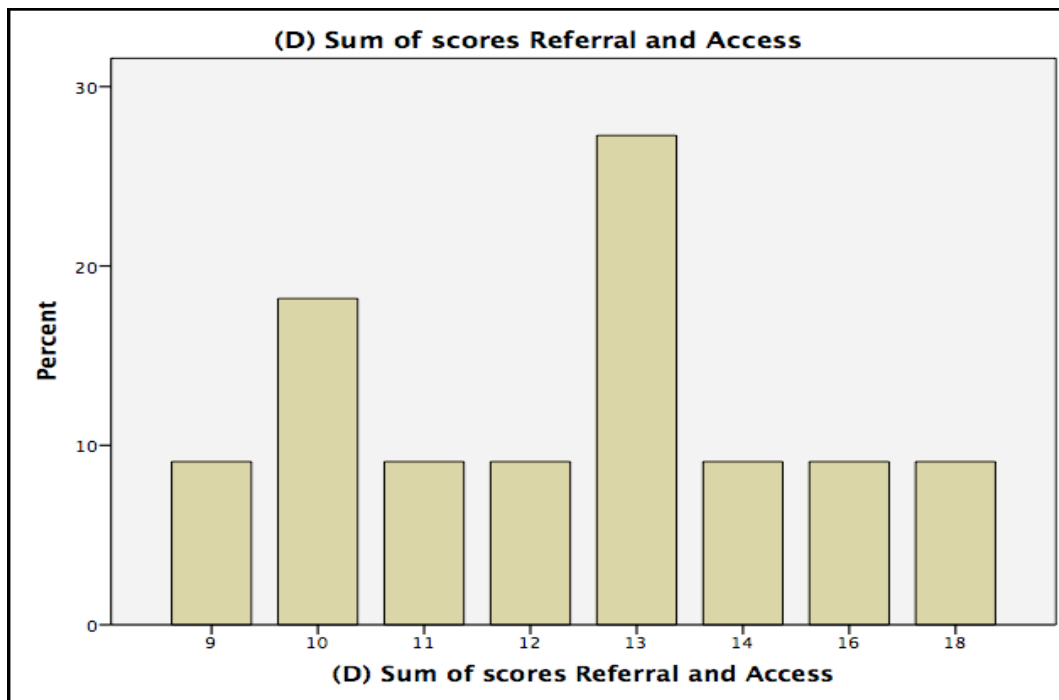


Figure 2. Sum of scores of Assessment and Care planning section

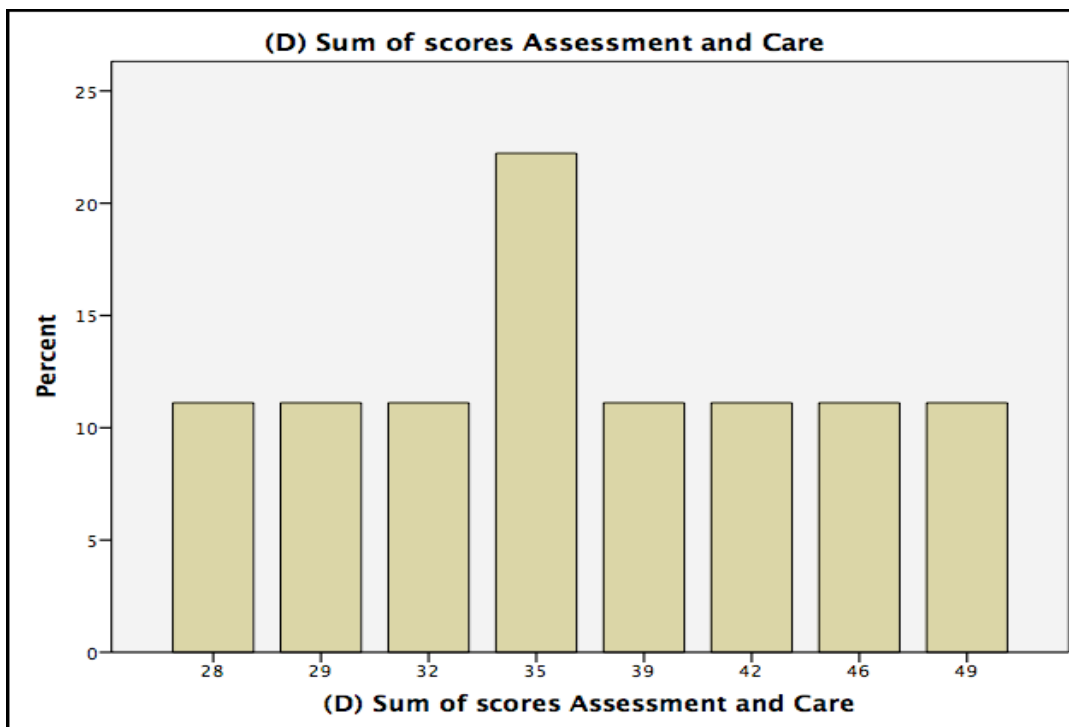


Figure 3. Sum of scores of Care and Intervention section.

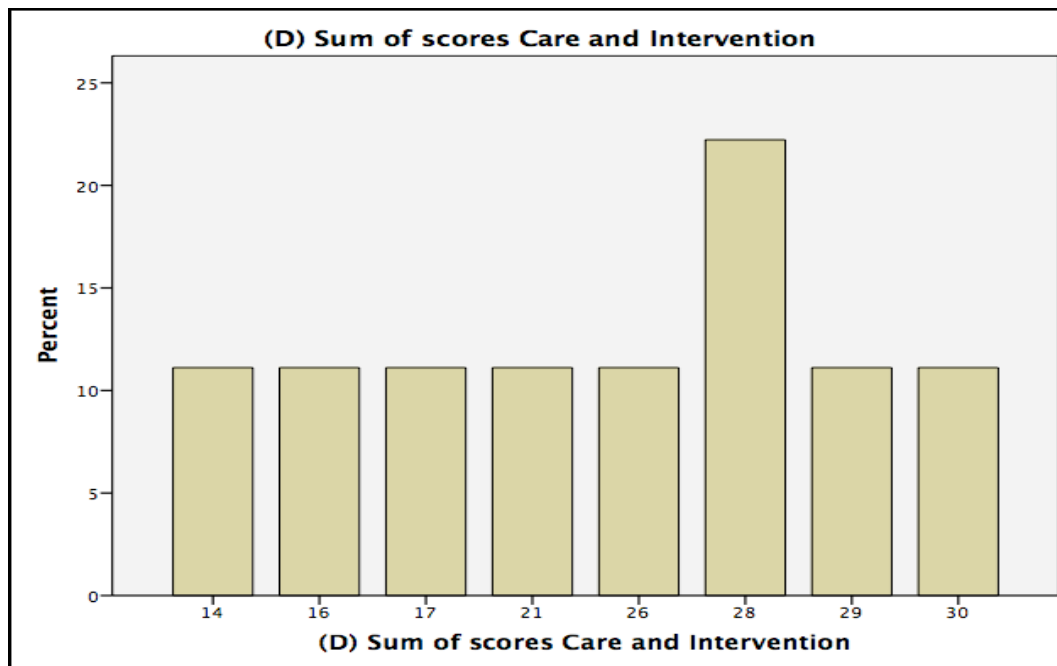
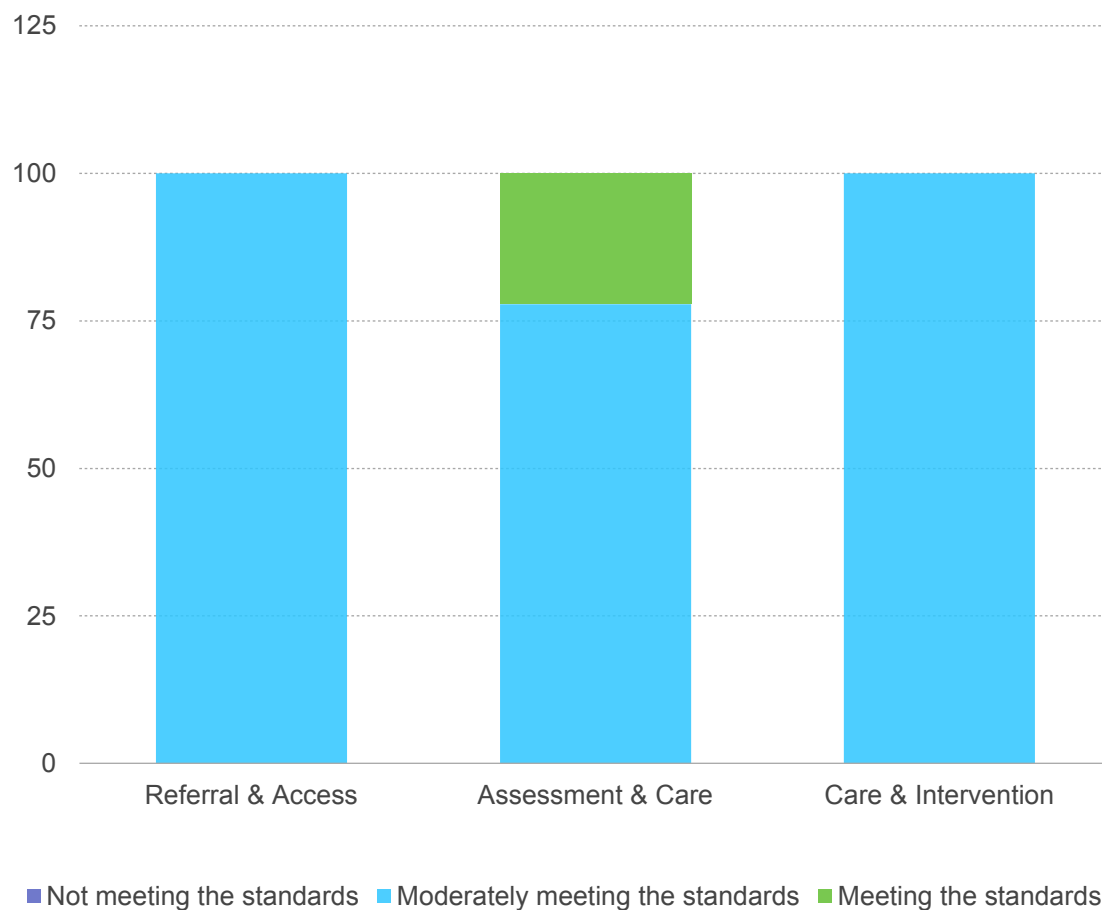


Figure 4. Validation of CAMHS subscales in Greek mental health services.



DISCUSSION

While this dissertation is being written, Greece has an agonizing choice to make. It should choose between the austerity measures enforced by the EU and the threat of flight out of the common currency which will lead the country to chaos. During the last 6-7 years, Greek people have suffered not only from the economic recession, but mostly from the psychological damage of uncertainty and pessimism. Vulnerable people such as children and citizens with mental disorders pay the highest price of this desperate situation.

Under these circumstances it was very difficult to perform a more in depth, widespread and comprehensive study of evaluation of services. Additionally, there was no help from the Ministry of Health, although they were asked to contribute.

In this dissertation, the evaluation done refers only to outpatient public CAMHS in Attica, whose prefecture includes Athens. Twelve out of twenty services corresponded to evaluation. There are many services which have closed down or under function, due to the financial crisis and it is impressive that we managed to collect even some data. Also in some cases there was much bureaucracy (administrative permission) and it was not possible to wait for the data. Nevertheless, we have a picture (the first in Greek literature) where the audit of greek CAMHS against the National British Standards shows the strong and weak points of services and confirms that in the middle of an undeclared war, greek CAMHS work satisfactorily.

The results of the evaluation agree with the views published by greek services, that CAMHS in Greece lack preventive-promoting programs in community and electronic data records, but they have a significant high level in care and intervention (Kolaitis, Fissas, Christogiorgos, et al, 2010). Some preventive projects funded by the EU and donors had been started by CAMHS, but due to the crisis were not possible to continue.

As we see from the charts bars:

In the section of **“referral and access”**

Questions referred to connections of services with each other and the communication among them, are not satisfactorily answered (1.1.3-1.3.1-1.4.3-1.4.2).

On the contrary questions referred to the safety of patient and the security of an emergency reference are answered satisfactorily (1.13b-1.2.1-1.3.2).

In the section of **“assessment and care”**

Most of the questions have been answered very positively, especially the questions referring to the needs of users and the provision of care (2.5.2a-2.5.4-2.6.3-2.6.4). The expected no-compliance of services with the standards

is the lack of evaluation measures as feedbacks from users, especially written ones (2.4.6-2.6.1-2.6.5).

In the section of **“care and intervention”**

Questions referred to multi-disciplinary care provision after assessment and appropriate treatment decided, are answered positively (3.1.1-3.1.3-3.4.2). Also it seems that many questions referred to data collection are appropriately answered, at least every user has his/her own file (3.4.3)

Again questions referred to feedback from users and to their participation of the organization of services don't meet the standards (3.5.2-3.6.1-3.6.2-3.6.3)

Figure 4 show us that the services examinees meet the three sections of British Standards in a moderate level between 26% and 75%. Two of these services meet the standards between 75% and 100%. The British Network has other ways to make the percentage of compliance more precise based on their literature.

That indicative study for Attica CAMHS wishes to be the beginning of an evaluation of greek CAMHS and the quality assurance of care provided.

The audit of services would be an instrument for amelioration and not for persecution and financial cuts.

If stakeholders contribute to the design of care provided and data collected will be relevant to clinical practice then the resistance of professionals will be reduced and the barriers of evaluation will be overcome.

In Greece, evaluation of services is not a common practice. There is a kind of quality measurement but there are not strategies, programs and standards to guide services.

For countries with more organized CAMHS, an evaluation process is necessary.

In the USA, a policy priority for the past 2 decades is for the child welfare system to receive high-quality mental health services. Professional organizations have proposed standards of care specifically tailored for the child population. The American Academy of Child and Adolescent Psychiatry in 2001 proposed a number of standards (first for foster services then extended to all CAMHS) (R.Raghavan 2010). A key informant survey of state and county mental health agencies found, that only one third of all mental health agency respondents reported being aware of these standards (Raghavan R, Inkelas 2007). Another study found that fewer than half of all counties had policies regarding mental health assessments for children in child welfare (Leslie LK 2003). The study of 2010 of the National Institute of Mental Health in the USA found that only half of all children receive care consistent with at least 1 index of national standards; less than 1 in 10 receives care consistent with all indices (R. Raghavan 2010)

In Canada, the development of national standards to ensure the quality of mental health care was started in 1917. Today there is an accreditation process where mental health services are examined against the national standards (Accreditation institute of Canada).

In Australia, a Scoping Study on the Implementation of National Standards in Mental Health Services in August 2014 found that the services reported either 'fully implemented' or 'were working towards implementation' more than those reporting they 'were not currently able to implement' any of the 10 standards. The standards that were most commonly reported as being fully implemented were:

- Standard 1: Rights and responsibilities (60%)
- Standard 2: Safety (59%).

The standards most often reported as not able to be implemented were:

- Standard 5: Promotion and prevention (9%)
- Standard 9: Integration (5%).

(Australian Commission on Safety and Quality in Health Care 2014)

For our study we have used the British national standards for community CAMHS last edition of 2012. British CAMHS use the standards as guidance to best practice of care delivery. They conduct self-review and peers review audit in order to prioritize development plans. Some evidence from the last performance of services against the British standards are:

In Scotland, CAMHS respond to the first three standards (Referral and Access Assessment and Care Planning, Care and Intervention), in 65%, 86% and 77% relatively.

In East Midland 86%, 94% and 89%.

In Wales 68%, 79%, 76%. In South 81%, 94%, 88% (Quality Network for community CAMHS).

Taking into consideration the huge socioeconomics differences between the UK and Greece the divergence is not so large. We see that also in the UK the second standard regarding the assessment and care planning is met in a greater degree than the other ones.

WHO has created a quality rights instrument which tries to ensure the quality of mental health services.

The WHO toolkit for evaluation of mental health services is based on UN human rights convention and provides practical information on the quality standards that need to be met in mental health care regarding the assessment of services (WHO quality rights: service standards and quality in mental health care 2012).

Nevertheless many authors agree that due to the complexity of care provided by CAMHS, managing quality on basis of external standards alone is not a reliable indicator for quality assurance (Priebe S 2000). Staff relationship with patients should be considered in combination with tailor-made interventions based on the real needs of each case.

CONCLUSIONS

A characteristic of our times is the struggle of social and care structures to keep up with the minimal of standards of quality of care. Even though practitioners do their job well, a number of resistances and systemic obstacles prevent the services from effective delivery of care.

As Bessel A. van der Kolk et al. (1996:25) emphasize, one core function of human societies is to provide their members with traditions, institutions, and value systems that can protect them against becoming overwhelmed by stressful experiences. Among the greatest discoveries in the post-war social and health care system was Donald Winnicott's finding of the holding function of the mother (holding), which can be extended to the wider society with its institutions, services, infrastructures and regulations.

It seems that the modern society doesn't always succeed to address contemporary issues such as child and adolescent mental health. When IACAPAP the International Association for Child and Adolescent Psychiatry as a body speaking on behalf of children and adolescents referred to structures for the child-adolescent mental health in 1966, the practitioners had nothing to do with the planning and the work involved. This was a responsibility of the international President and of his Committee. The absence of active presence of the practitioners in the planning of child-adolescent mental health is one of the factors which has created difficulties in the delivery of care. Another is the lack of human and financial resources.

Child-Adolescent Mental health is a very expensive issue.

Child-Adolescent services need money in order to be appropriate and effective. The diagnostic process for every case doesn't include only the child-patient but at least two more persons, the mother and father. Sometimes it includes more than three persons, if there are brothers and grandparents or any important person from the child's environment. Also each case should be assessed by a team of practitioners and the intervention should be at several levels, such as medical, social and educational. All these issues need knowledge, coordination, time, infrastructures and multi-disciplinary team.

Governments know that investing in children and adolescents is an investment for the future of a country and child mental health is a kind of public mental health prevention. They know that the establishment and quality of outpatient CAMHS and preventive projects in schools is more cost effective than the results of lasting mental health disorders. However, nowadays we see dramatic cuts in the budgets of CAMHS even in countries with a tradition of such services.

The reason is not only the global financial crisis. The mentality of the 70s and 80s has changed. The revolution of psychiatric reform and the achievement of mental wellbeing as a human right have faded. Despite the progress of science and technology, people have regressed to more primitive psychic status where the right of the Strong is the Law of the government. Vulnerable children and adolescents having troubles in family, school and society, are not considered people with high productivity potency.

However from our clinical practice we know very well that fragile, emotional disturbed children, if they have appropriate care from mental health services or from school based programs, in the majority of cases, not only do they succeed to overcome their difficulties, but become more creative, sensitive and innovative people than the “healthy” ones.

Unfortunately practitioners in CAMHS weren’t interested in making all this evidence of their job known, or they don’t have the opportunity to do that. Also, when there are not the mechanisms for ensuring the quality of care provided, we cannot have feedback helping us to identify the strong and weak points of services.

During the last 25 years, the greek mental health services for children and adolescents have been extremely developed and despite the financial crisis, they keep having a high quality of functioning. Despite bureaucratic obstacles, amateur political manipulations and resistance to evaluation of some professionals, CAMHS have a significant number of cases which seem to be treated well, according to this study results.

In this study we saw that the Greek CAMHS examined against the British Standards, seem to function according a quality level.

That may happen for two reasons in my opinion:

Firstly, it is due to CAMHS well-functioning from the beginning of their establishment. Thanks to the first greek child-adolescent psychiatrists trained abroad and the significant financial and scientific help of the EU, Greek CAMHS had the chance of a good “curriculum”. Secondly it is due to the high level of professionalism of CAMHS’ staff.

Indeed the human resources of services in Greece are characterized by additional training in psychotherapy, working abroad, lifelong learning and courage, helping them to overcome political, financial and personal obstacles.

“...it will happen but it will take time.” John Bowlby “...costing not less than everything. T.S Eliot

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Appendix 1. Sections of Children's and adolescents' mental health services (CAMHS) standards.

Quality Network for Community CAMHS Self-Review Workbook	
Section 1	Referral and access
Section 2	Assessment and care planning
Section 3	Care and intervention
Section 4	Information, consent and confidentiality
Section 5	Rights and safeguarding
Section 6	Transfer of care
Section 7	Multi-agency working
Section 8	Staffing and training
Section 9	Location, Environment and Facilities
Section 10	Commissioning

Appendix 2. CAMHS items of Referral and Access section.

CAMHS work with all potential referrers to ensure referrals are appropriate, timely and co-ordinated

1.1.1 CAMHS offer consultation and training to frontline referring services

1.1.2 CAMHS disseminate clear referral criteria to referrers, including criteria for varying levels of response

1.1.3 CAMHS have documented up-to-date procedures and response times agreed with other agencies for:

1.1.3a • Routine referrals

1.1.3b • Emergency referrals

1.1.4 When referrals are made which do not meet the service's criteria, staff inform the referrer why the referral has not been accepted and of alternative options

Young people and their parents (where appropriate) are fully involved and informed during the process of referral so they know what to expect

1.2.1 Staff provide young people and their parents/carers with written information about the service prior to or during their first attendance

1.2.2 CAMHS provide information about how young people on the waiting list can access help while they wait for an appointment

1.2.3 Young people are kept informed about the progress of their referral and estimated wait for the first appointment

Young people and their parents/carers can access CAMHS easily and according to their need

1.3.1 There are documented, up-to-date referral pathways into CAMHS via a range of local services

1.3.2 Appointments are flexible and responsive to the needs of young people and their parents/carers where appropriate

1.3.3 The service has a policy or procedure, which may include a risk assessment process that staff follow when young people and their parents/carers do not attend appointments.

1.3.4 The service identifies where difficulties exist for particular groups to access the service and implements and monitors strategies to address these difficulties

CAMHS have systems in place to monitor access and referral

1.4.1 The number and characteristics of referrals to the service are monitored, including as a minimum the age, gender, ethnicity and source of referrals

1.4.2 Missed appointments (DNAs) are monitored monthly and reviewed in order to identify where access difficulties may exist

1.4.3 Data on referrals and missed appointments/early disengagement is compared with local population statistics (for example, national census data) to help
identify where access difficulties may exist

1.4.4 The service records information on waiting times

Appendix 3. CAMHS items of Assessment and Care section.

Young people receive timely mental health assessments

2.1.1 Young people with a routine referral receive a mental health assessment within 6 weeks

2.1.2 Young people with urgent or emergency mental health needs receive a mental health assessment within 24 hours or the next working day

Assessments are effectively co-ordinated with other agencies so that young people and their parents/carers are not repeatedly asked to give the same information

2.2.1 There is a clear identification of whether the young people or parents/carers are involved with or have access to other agencies

2.2.2 Prior to assessment, the assessing practitioner accesses relevant previous information to minimize the number of forms and assessments young people and their parents/carers are required to complete

2.2.3 If additional information or liaison with other professionals is required, the assessing practitioner ensures that permission to access this is first sought from the young person or parent/carer as appropriate

Staff have the necessary competencies and resources to conduct assessments and arrange the next steps

2.3.1 Clinicians requiring access to medical assessment and investigations have an agreed pathway to access this when necessary

Young people and their parents/carers experience assessment as collaborative and are fully informed and involved

2.4.1 Staff check that young people and their parents/carers understand the purpose of the assessment and possible outcomes as fully as possible before it is conducted

2.4.2 Appointment letters for young people and their parents/carers about assessments explain:

2.4.3 During assessment young people's views, wishes, and feelings are actively sought and recorded by the assessing practitioner, as far as possible with regards to capacity

2.4.4 During assessment, parents or carers' views, wishes, and feelings are actively sought and recorded by the assessing practitioner (where appropriate)

2.4.5 Young people and parents/carers are provided with verbal feedback on the outcome of their assessment at the session

2.4.6 Written feedback from the assessment is provided to young people and parents/carers within 10 working days

Assessments are individual and according to need

2.5.1 Case notes show evidence that assessments include consideration of:

2.5.1a • the young person's family and community needs and context

2.5.1b • the young person's abilities and strengths as well as their difficulties

2.5.1c • the young person's views and goals for treatment

2.5.2 Case notes show evidence that plans for intervention involve consideration of:

2.5.2a • the young person's individual mental health needs

2.5.2b • the young person's level of functioning and communication needs

2.5.2c • the holistic needs of the young person, including social, physical, emotional, educational, cultural and spiritual needs and context

2.5.2d • the wishes and goals of the family and their capacity to support interventions

2.5.2e • the capacity and willingness of other agencies to support the intervention

2.5.4 Staff ask young people about aspects of their physical health and discuss healthy lifestyles with young people and parents/carers

Young people have care plans which are regularly updated and shared with relevant parties

2.6.1 Young people have written care plans

2.6.2 Care plans are reviewed at every session and include discussions with the young person about whether the treatment is helping

2.6.3 A formal risk assessment review is carried out on referral to the service and reviewed every 3 months and on discharge

2.6.4 Risk is reviewed session by session

2.6.5 Young people and their parents are given copies of any written plans for intervention or have ready access to them (with the young person's consent where appropriate)

2.6.6 Plans for intervention are copied to other relevant agencies involved in the young person's care (with consent being sought as appropriate)

Care plans are collaborative and comprehensive, according to individual need

2.7.1 Care plans are developed in partnership with young people and their parents/carers, including agreeing outcomes important to them, and their views are recorded in their note

2.7.2 Wherever an element of intervention detailed in the care plan does not take place, reasons for this are recorded in the case notes and discussed with the young person and their family

Appendix 4. CAMHS items of Care and Intervention section.

The service offers a range of interventions according to individual and family needs

- 3.1.1 Clinicians are able to gain multi-disciplinary input on cases when needed
- 3.1.2 Interventions are provided in accordance with the NICE guidelines and/or the best available evidence
- 3.1.3 Where medication is used, prescribing follows protocols and best practice (e.g. NICE guidelines), and is closely monitored and regularly reviewed by an appropriately qualified, experienced practitioner
- 3.1.4 Young people and parents/carers can access support that is appropriate to any disabilities or needs additional to their mental health needs.

Young people receive prompt care and intervention

- 3.2.1 Young people assessed as requiring treatment see an appropriate clinician within 6 weeks of assessment
- 3.2.2 Young people and their parents/carers are informed of how to get appropriate mental health advice in an emergency if necessary

Staff provide support and guidance to enable young people and their parents/carers to help themselves

- 3.3.1 CAMHS liaise with other appropriate clinicians to meet any mental health needs identified within the young person's family
- 3.3.2 Young people and parents/carers are guided in self-help approaches where appropriate
- 3.3.3 Young people and their parents/carers are informed about local voluntary organizations and self-help groups, including culturally specific groups and organizations where relevant

Young people and parents/carers experience collaborative and consistent care

- 3.4.1 Young people and their parents/carers have regular discussions with clinicians about the young person's progress and, where relevant, diagnosis

3.4.2 Young people and their parents/carers are provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention

3.4.3 All young people have a named member of staff who co-ordinates their care and is named in the young person's notes

3.4.4 Young people and their parents consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise

3.4.5 There is a mechanism for young people to change their clinician if there are problems without prejudicing their access to treatment

Outcome measurement is routinely undertaken

3.5.1 Staff have protected time to collect and collate outcome information

3.5.2 Case records include the results of measurement using at least one validated outcome measure

3.5.3 Outcome measures are evaluated from the perspective of staff, young people and parents/carers at a minimum

3.5.4 Information from outcome measurement is fed back to staff, service-users and commissioners

3.5.5 Aggregated outcome data is used to inform individual plans for intervention, service evaluation and development. Guidance: this should be undertaken at a minimum of every 6 months

Young people and parents/carers are encouraged to give feedback on the service and responses are reported back to them

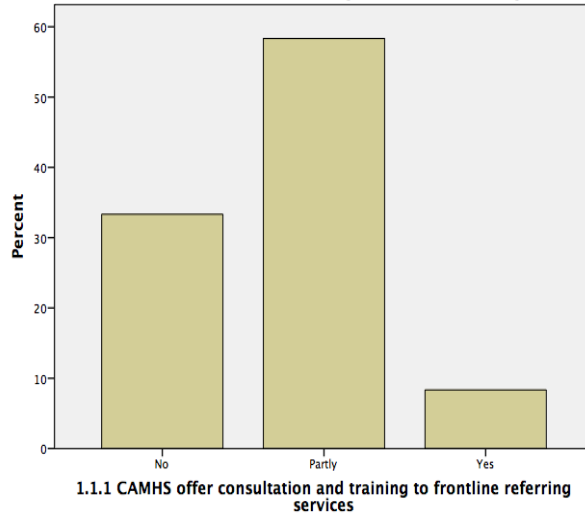
3.6.1 Young people and parents/carers are actively encouraged to give feedback on the service they receive

3.6.2 Young people are actively involved in service development

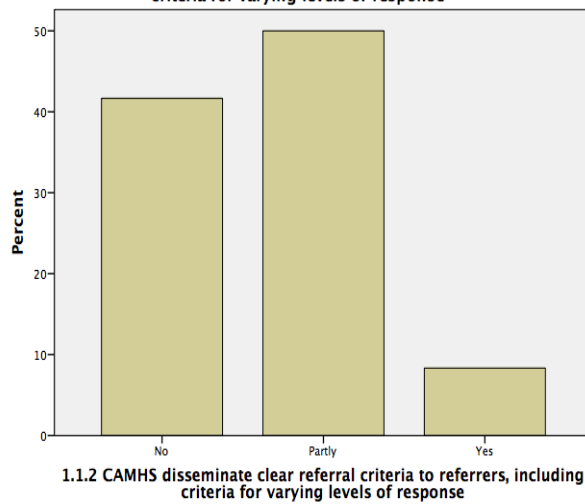
3.6.3 Feedback from young people and their parents is monitored and used to inform service evaluation and development

Bar charts of all subscale items (CAMHS)

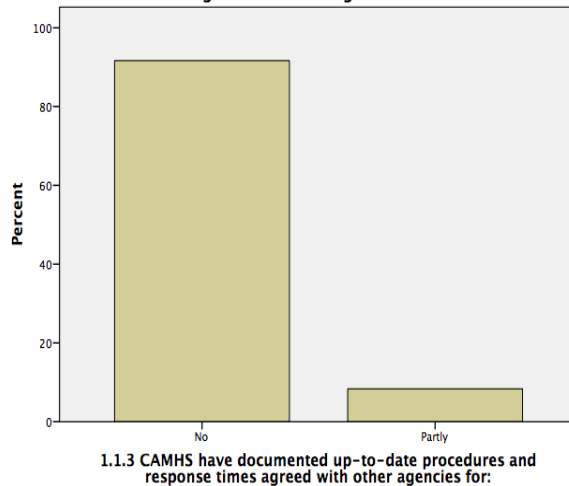
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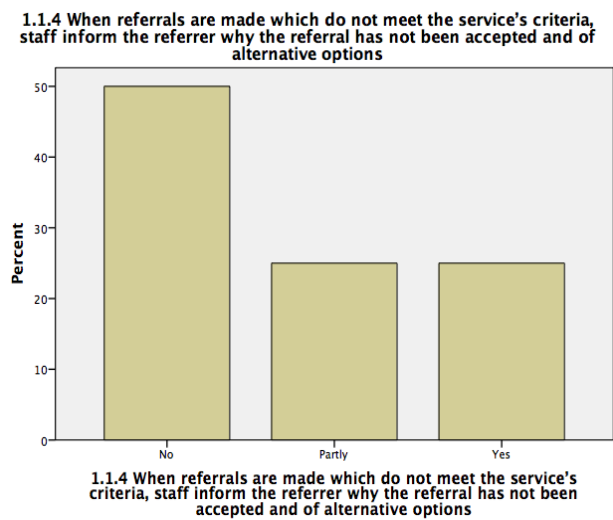
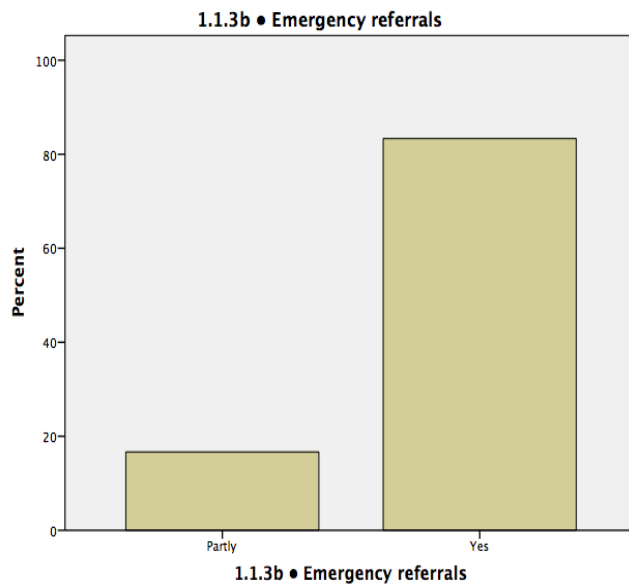
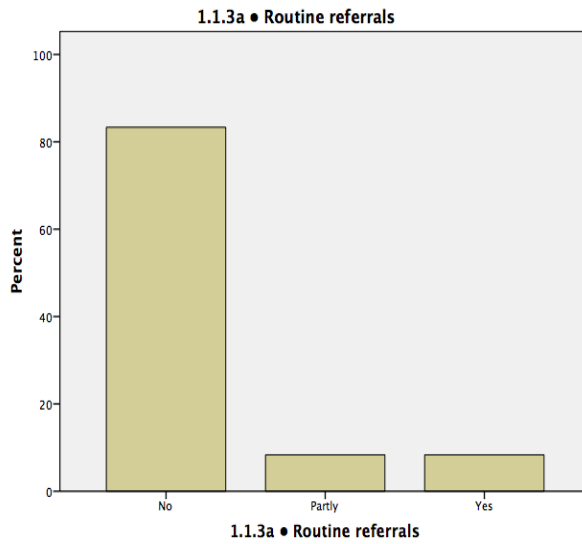


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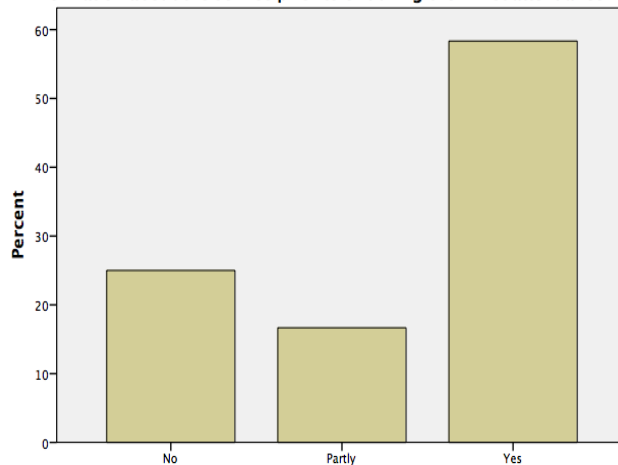


1.1.3 CAMHS have documented up-to-date procedures and response times agreed with other agencies for:



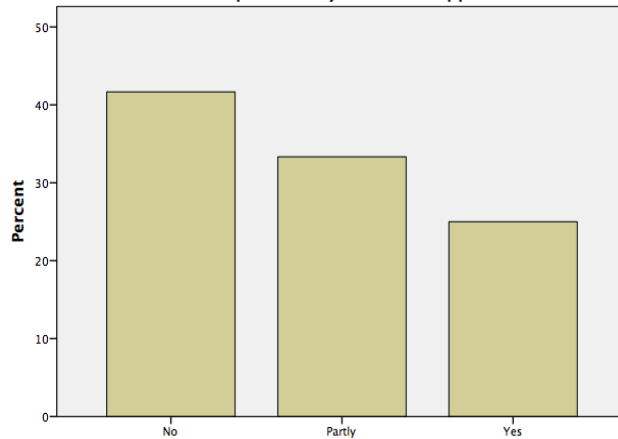


1.2.1 Staff provide young people and their parents/carers with written information about the service prior to or during their first attendance



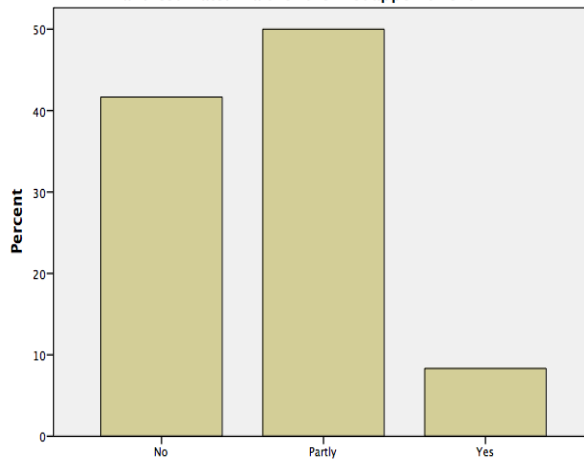
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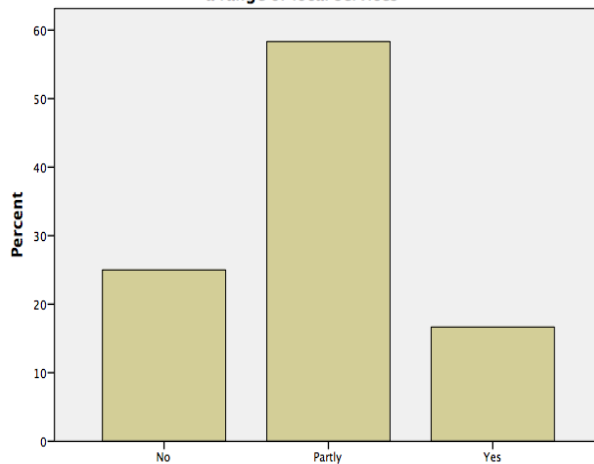
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1.2.3 Young people are kept informed about the progress of their referral and estimated wait for the first appointment



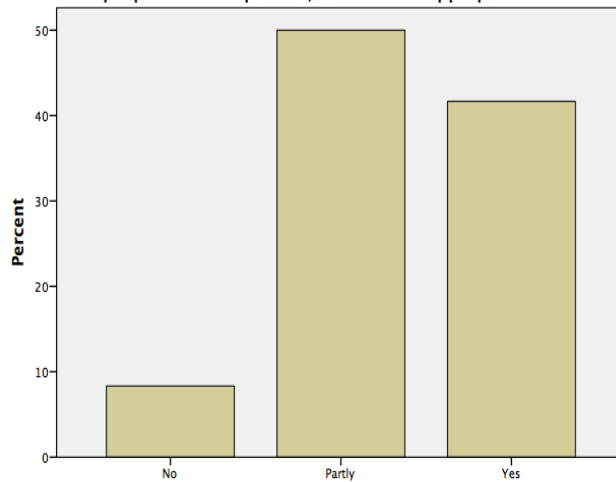
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1.3.1 There are documented, up-to-date referral pathways into CAMHS via a range of local services



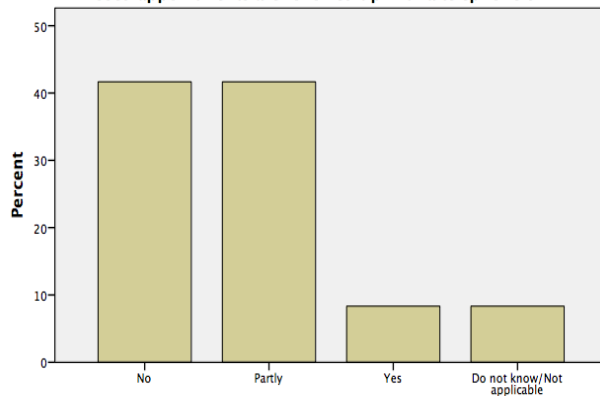
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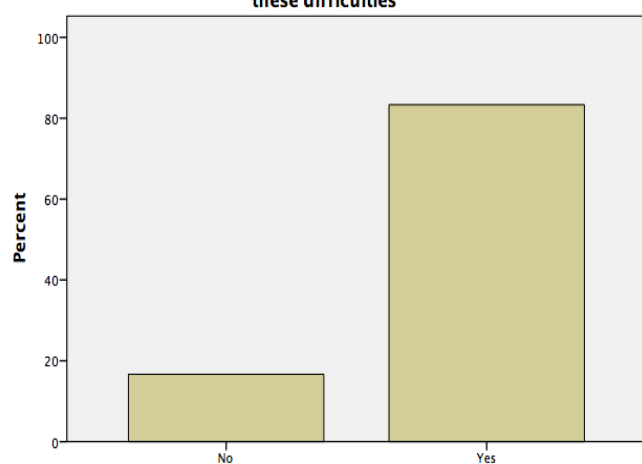
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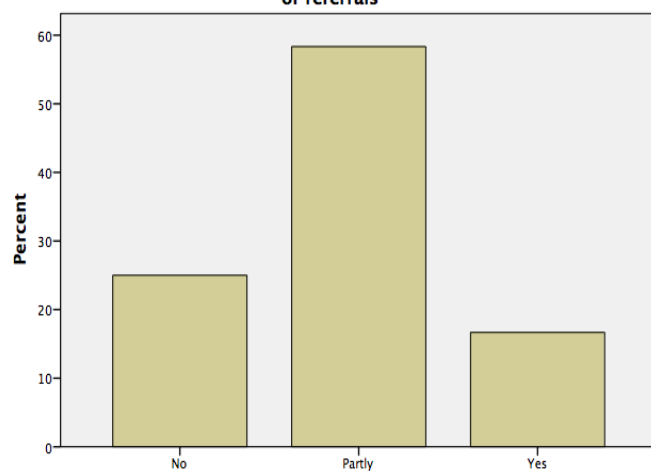
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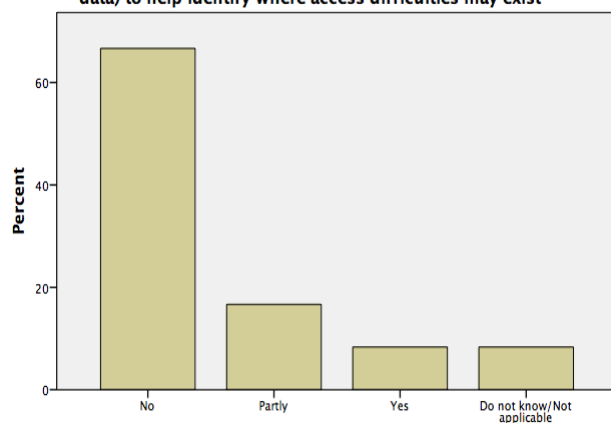
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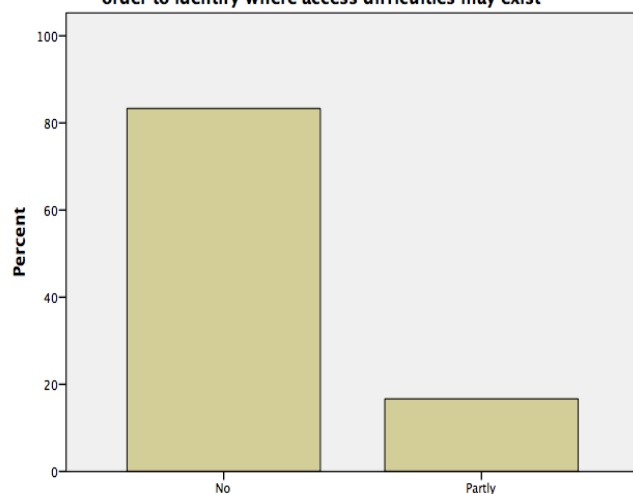
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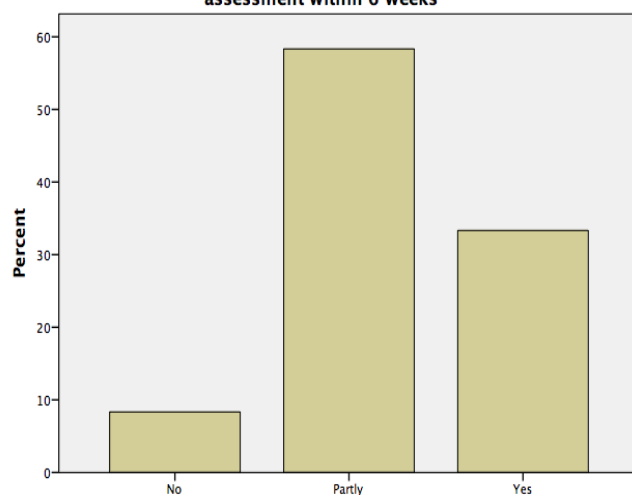
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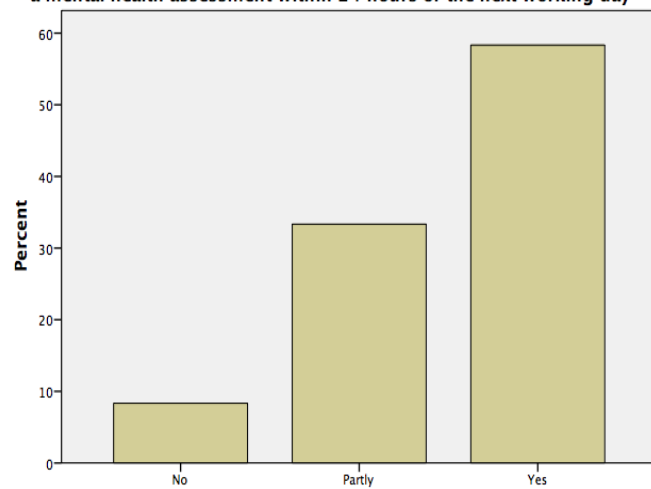
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2.1.1 Young people with a routine referral receive a mental health assessment within 6 weeks



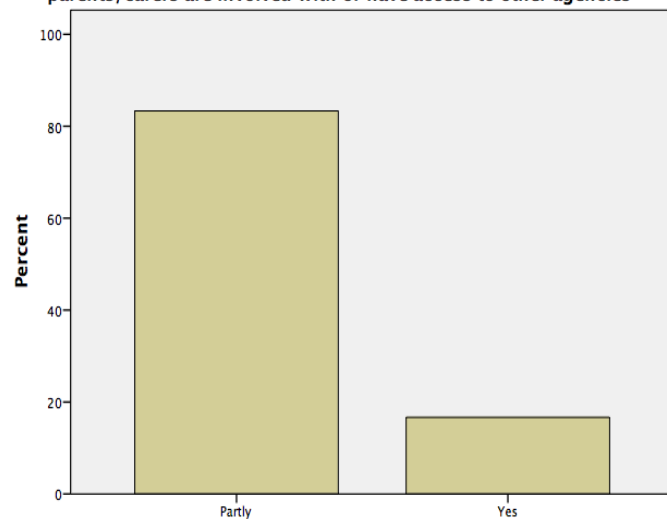
2.1.1 Young people with a routine referral receive a mental health assessment within 6 weeks

2.1.2 Young people with urgent or emergency mental health needs receive a mental health assessment within 24 hours or the next working day



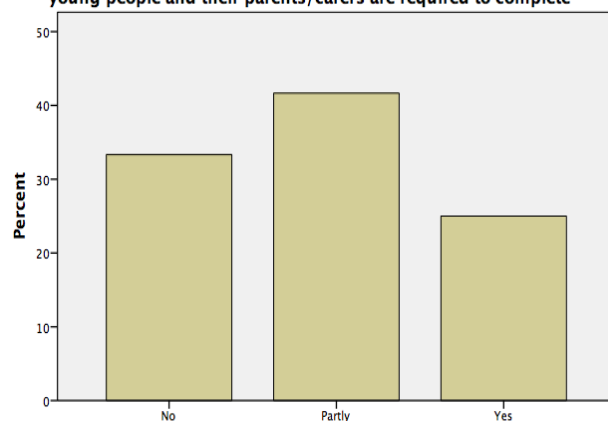
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2.2.1 There is a clear identification of whether the young people or parents/carers are involved with or have access to other agencies



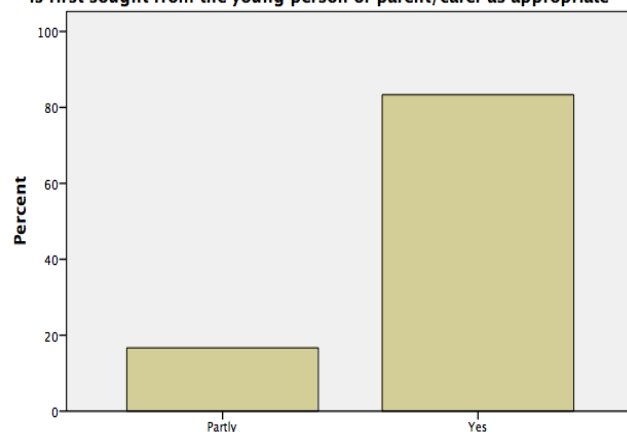
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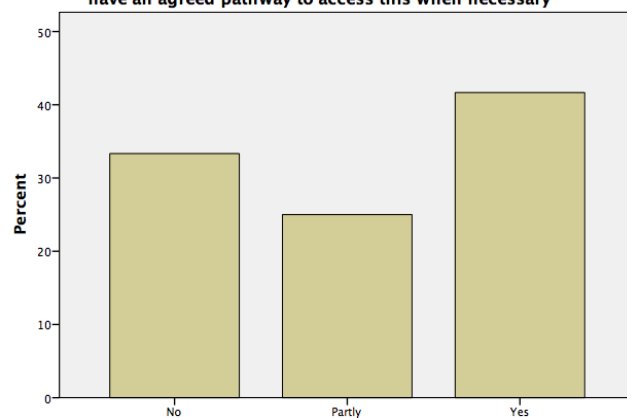
2.2.2 Prior to assessment, the assessing practitioner accesses relevant previous information to minimize the number of forms and assessments young people and their parents/carers are required to complete

2.2.3 If additional information or liaison with other professionals is required, the assessing practitioner ensures that permission to access this is first sought from the young person or parent/carer as appropriate



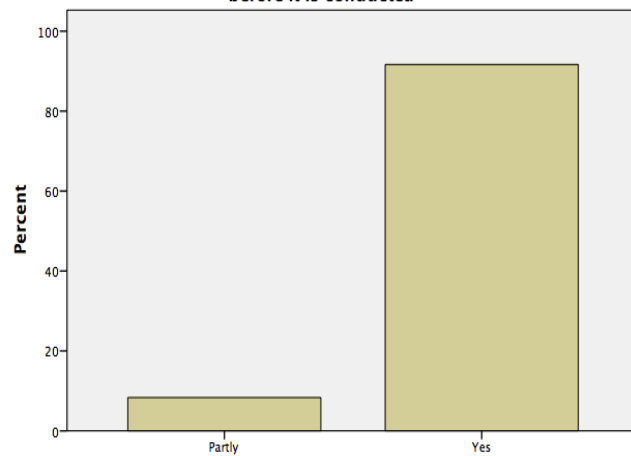
2.2.3 If additional information or liaison with other professionals is required, the assessing practitioner ensures that permission to access this is first sought from the young person or parent/carer as appropriate

2.3.1 Clinicians requiring access to medical assessment and investigations have an agreed pathway to access this when necessary



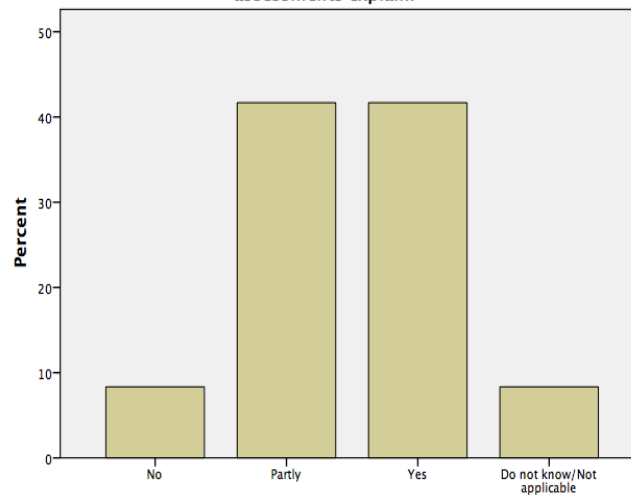
2.3.1 Clinicians requiring access to medical assessment and investigations have an agreed pathway to access this when necessary

2.4.1 Staff check that young people and their parents/carers understand the purpose of the assessment and possible outcomes as fully as possible before it is conducted



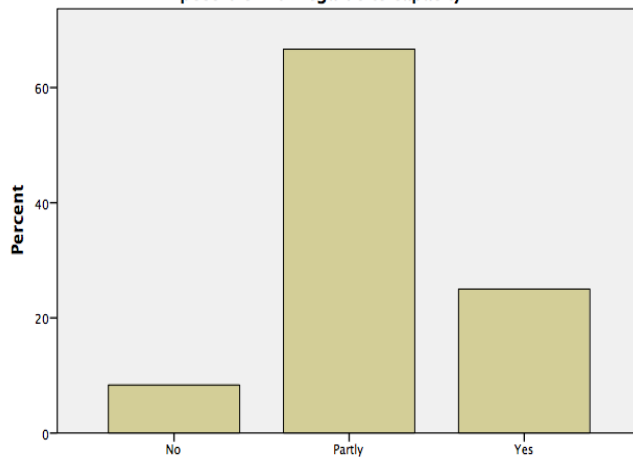
2.4.1 Staff check that young people and their parents/carers understand the purpose of the assessment and possible outcomes as fully as possible before it is conducted

2.4.2 Appointment letters for young people and their parents/carers about assessments explain:



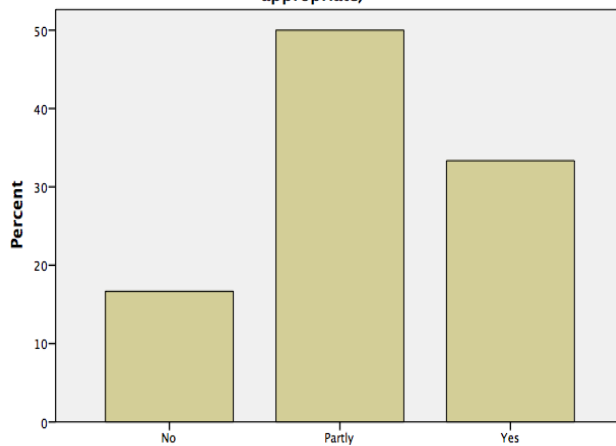
2.4.2 Appointment letters for young people and their parents/carers about assessments explain:

2.4.3 During assessment young people's views, wishes, and feelings are actively sought and recorded by the assessing practitioner, as far as possible with regards to capacity



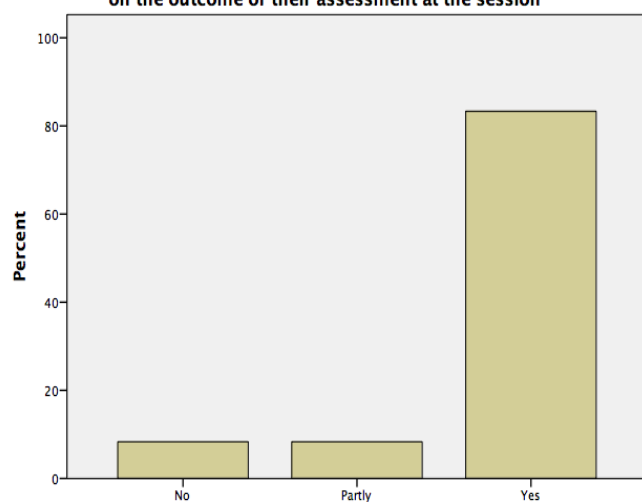
2.4.3 During assessment young people's views, wishes, and feelings are actively sought and recorded by the assessing practitioner, as far as possible with regards to capacity

2.4.4 During assessment, parents or carers' views, wishes, and feelings are actively sought and recorded by the assessing practitioner (where appropriate)



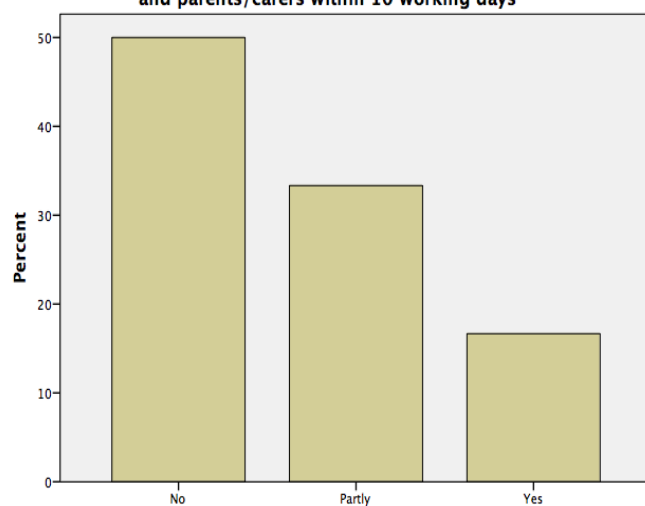
2.4.4 During assessment, parents or carers' views, wishes, and feelings are actively sought and recorded by the assessing practitioner (where appropriate)

2.4.5 Young people and parents/carers are provided with verbal feedback on the outcome of their assessment at the session



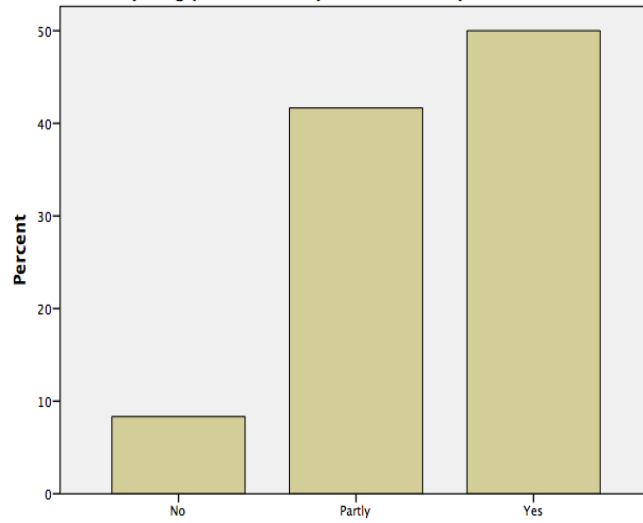
2.4.5 Young people and parents/carers are provided with verbal feedback on the outcome of their assessment at the session

2.4.6 Written feedback from the assessment is provided to young people and parents/carers within 10 working days



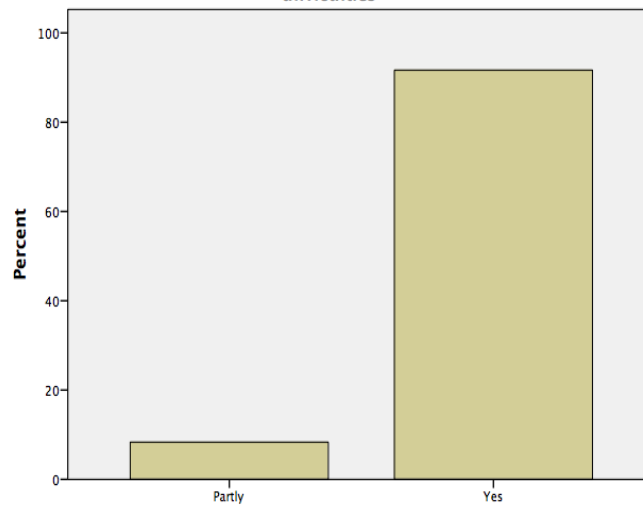
2.4.6 Written feedback from the assessment is provided to young people and parents/carers within 10 working days

2.5.1a • the young person's family and community needs and context

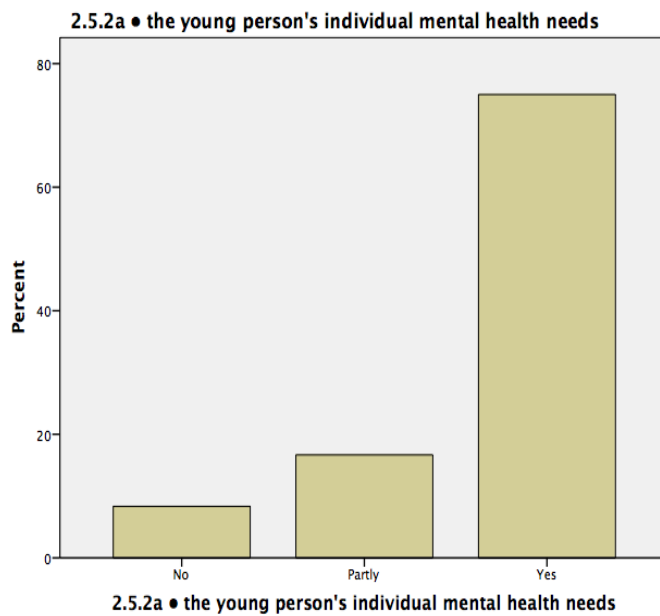
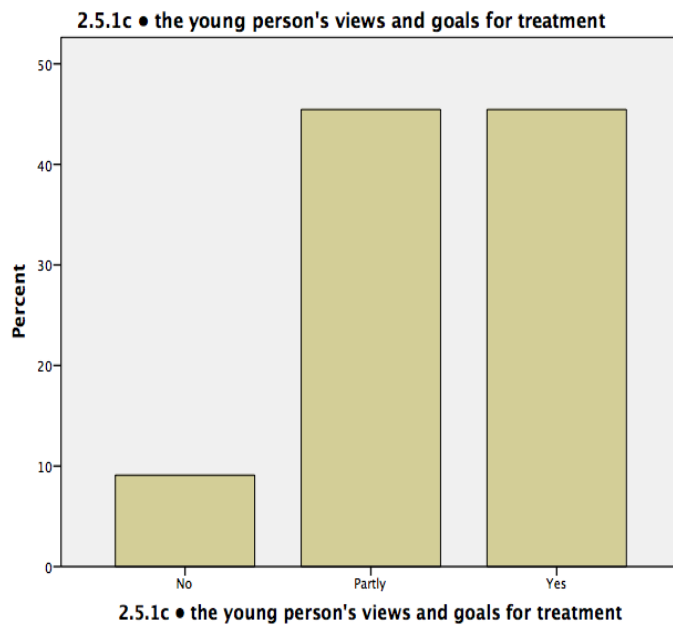


2.5.1a • the young person's family and community needs and context

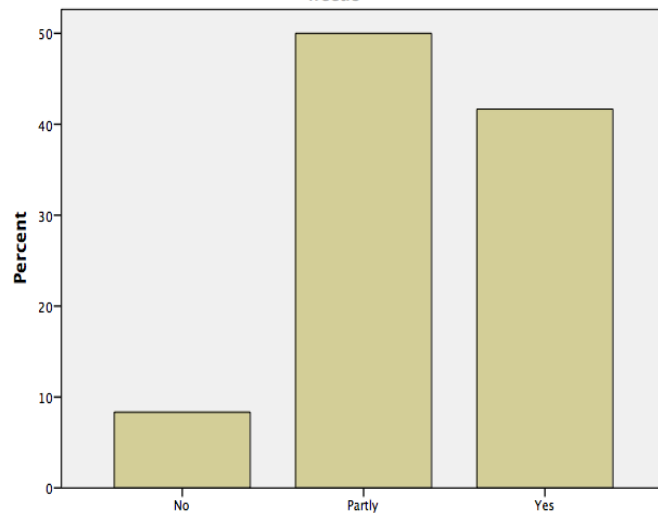
2.5.1b • the young person's abilities and strengths as well as their difficulties



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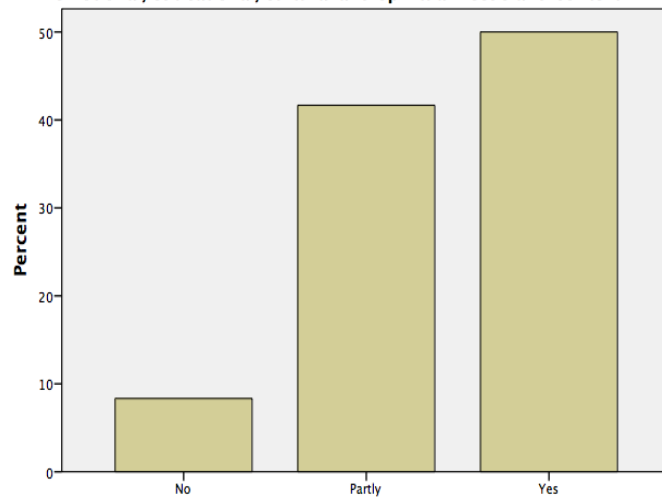


2.5.2b • the young person's level of functioning and communication needs



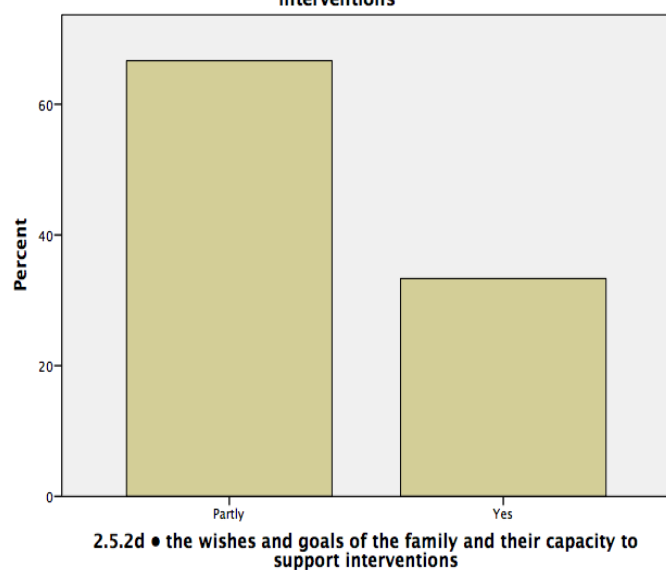
2.5.2b • the young person's level of functioning and communication needs

2.5.2c • the holistic needs of the young person, including social, physical, emotional, educational, cultural and spiritual needs and context

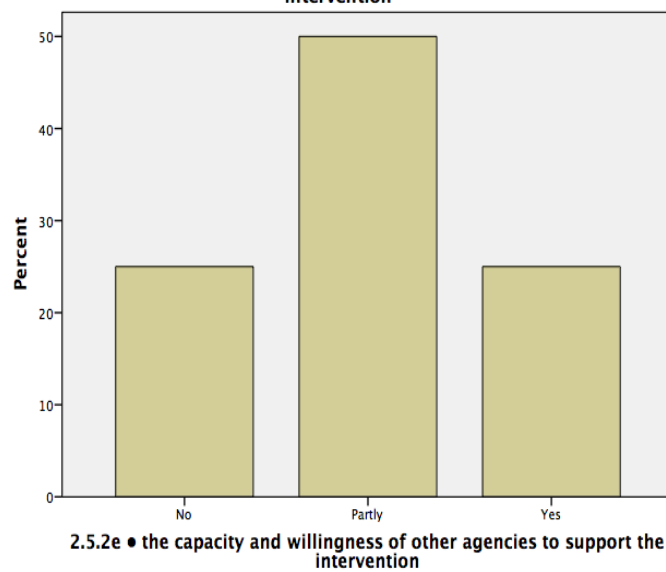


2.5.2c • the holistic needs of the young person, including social, physical, emotional, educational, cultural and spiritual needs and context

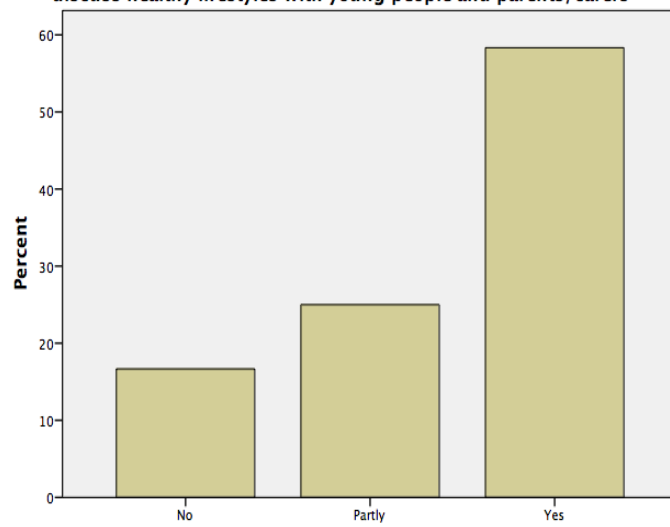
2.5.2d • the wishes and goals of the family and their capacity to support interventions



2.5.2e • the capacity and willingness of other agencies to support the intervention

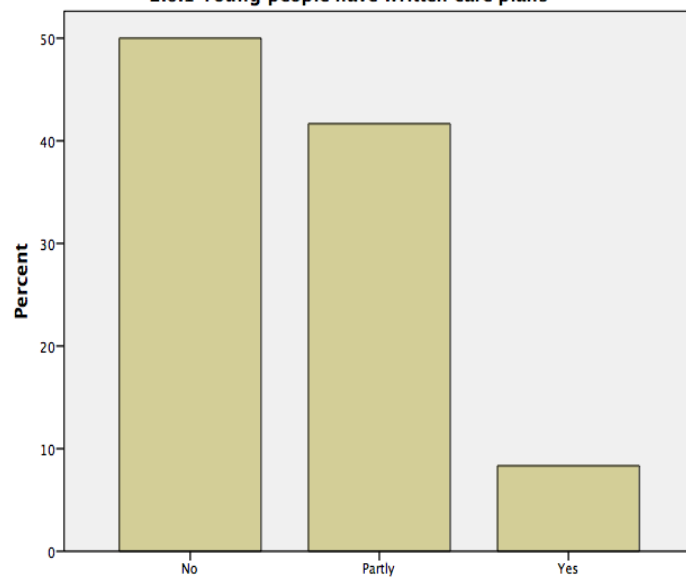


2.5.4 Staff ask young people about aspects of their physical health and discuss healthy lifestyles with young people and parents/carers



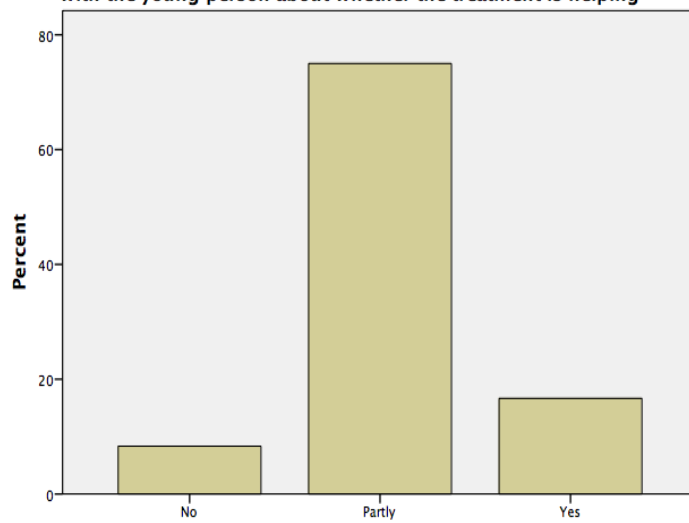
2.5.4 Staff ask young people about aspects of their physical health and discuss healthy lifestyles with young people and parents/carers

2.6.1 Young people have written care plans



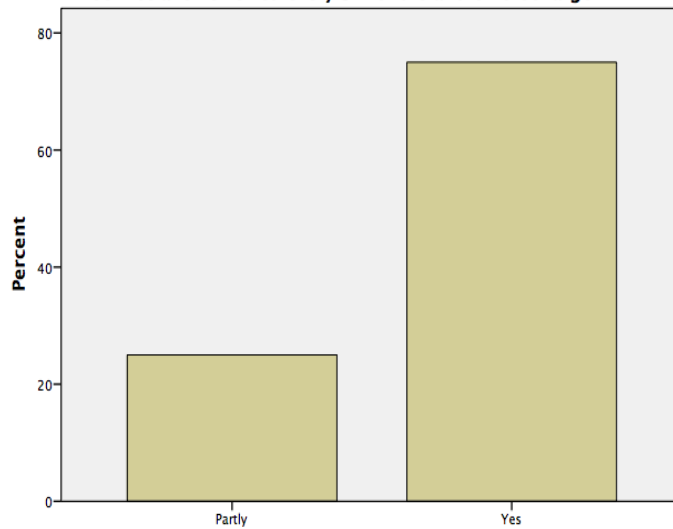
2.6.1 Young people have written care plans

2.6.2 Care plans are reviewed at every session and include discussions with the young person about whether the treatment is helping

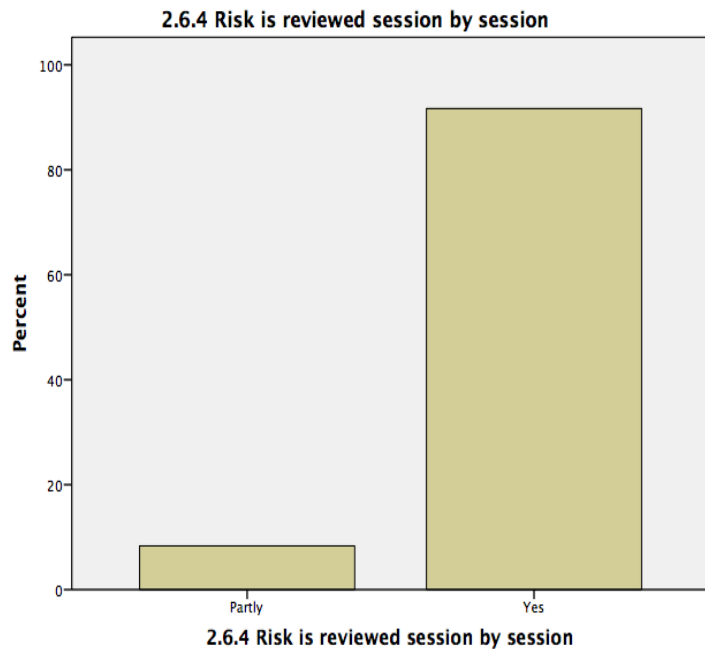


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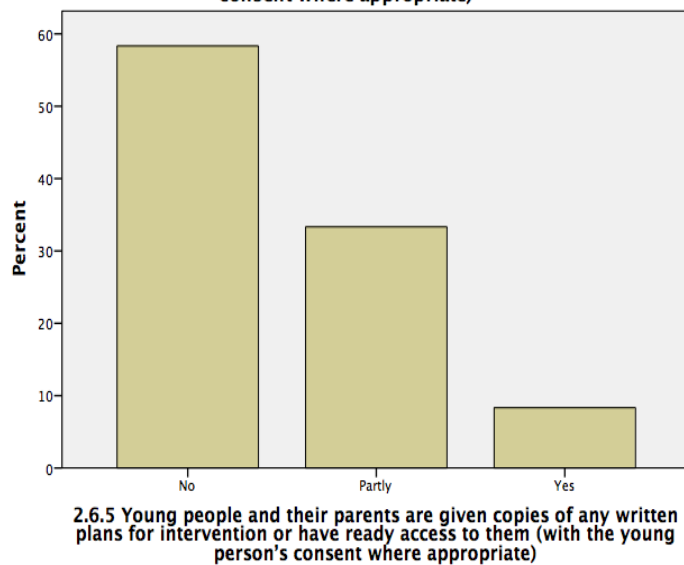
2.6.3 A formal risk assessment review is carried out on referral to the service and reviewed every 3 months and on discharge



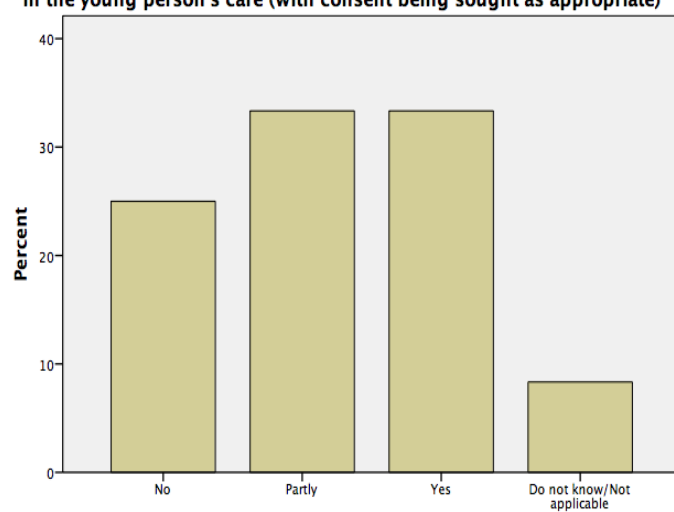
2.6.3 A formal risk assessment review is carried out on referral to the service and reviewed every 3 months and on discharge



2.6.5 Young people and their parents are given copies of any written plans for intervention or have ready access to them (with the young person's consent where appropriate)

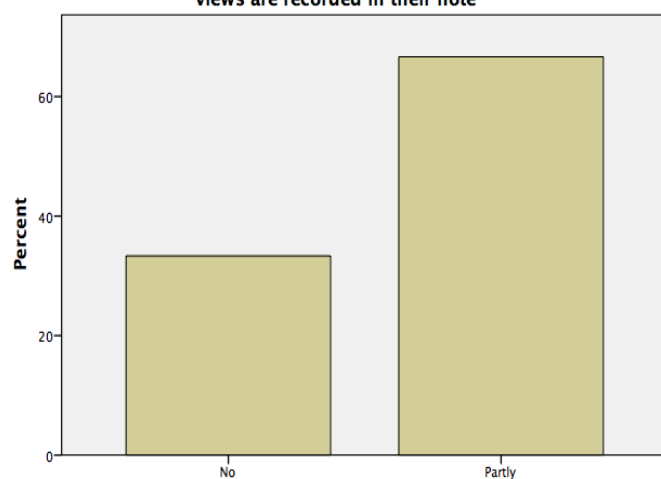


2.6.6 Plans for intervention are copied to other relevant agencies involved in the young person's care (with consent being sought as appropriate)



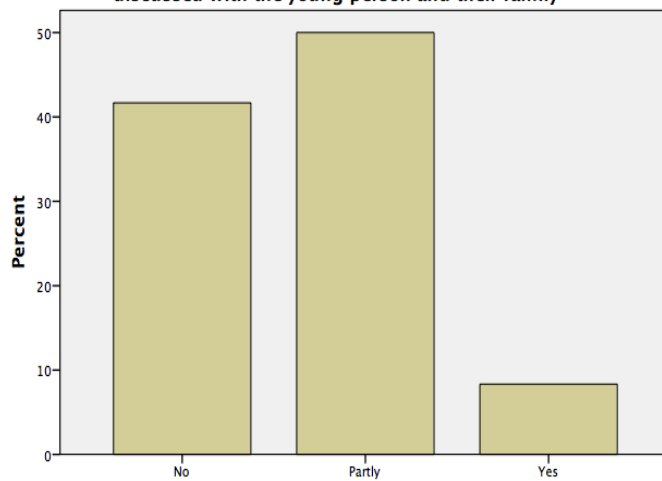
2.6.6 Plans for intervention are copied to other relevant agencies involved in the young person's care (with consent being sought as appropriate)

2.7.1 Care plans are developed in partnership with young people and their parents/carers, including agreeing outcomes important to them, and their views are recorded in their note



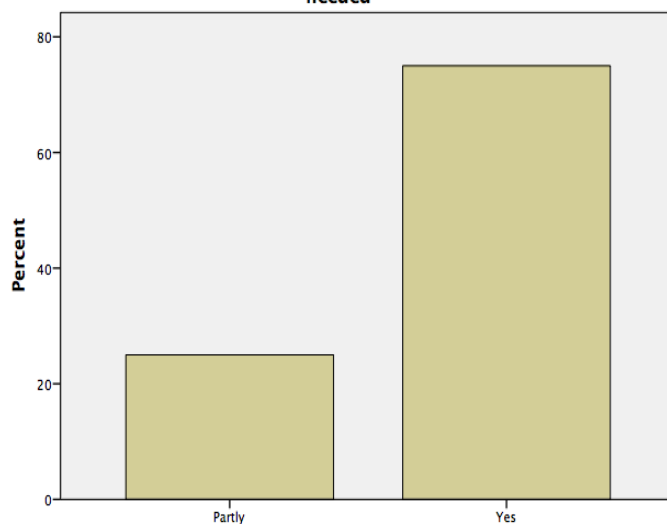
2.7.1 Care plans are developed in partnership with young people and their parents/carers, including agreeing outcomes important to them, and their views are recorded in their note

2.7.2 Wherever an element of intervention detailed in the care plan does not take place, reasons for this are recorded in the case notes and discussed with the young person and their family



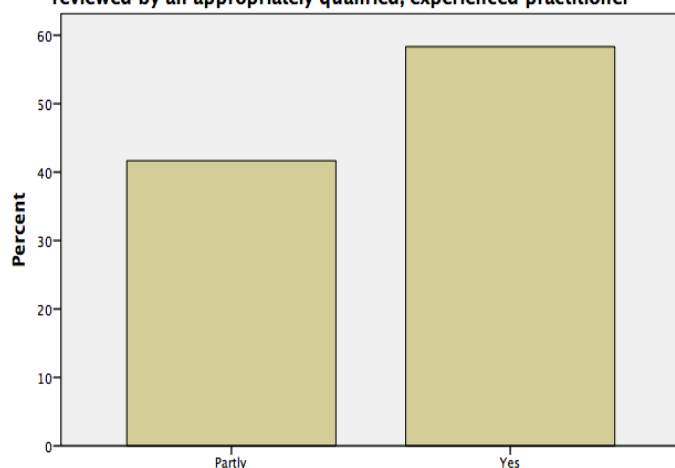
2.7.2 Wherever an element of intervention detailed in the care plan does not take place, reasons for this are recorded in the case notes and discussed with the young person and their family

3.1.1 Clinicians are able to gain multi-disciplinary input on cases when needed



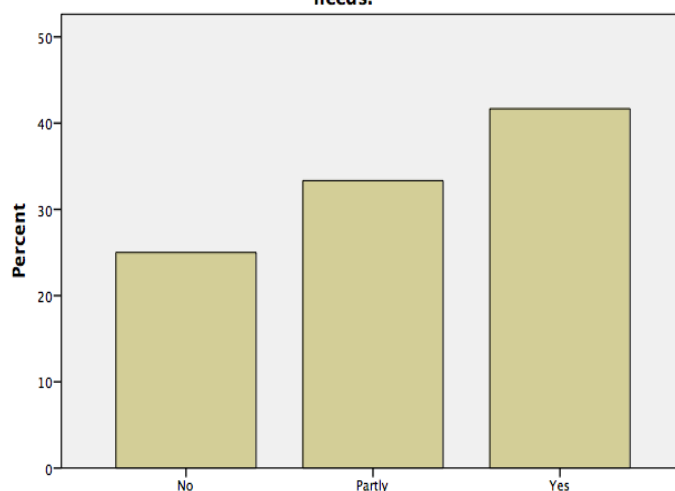
3.1.1 Clinicians are able to gain multi-disciplinary input on cases when needed

3.1.3 Where medication is used, prescribing follows protocols and best practice (e.g. NICE guidelines), and is closely monitored and regularly reviewed by an appropriately qualified, experienced practitioner



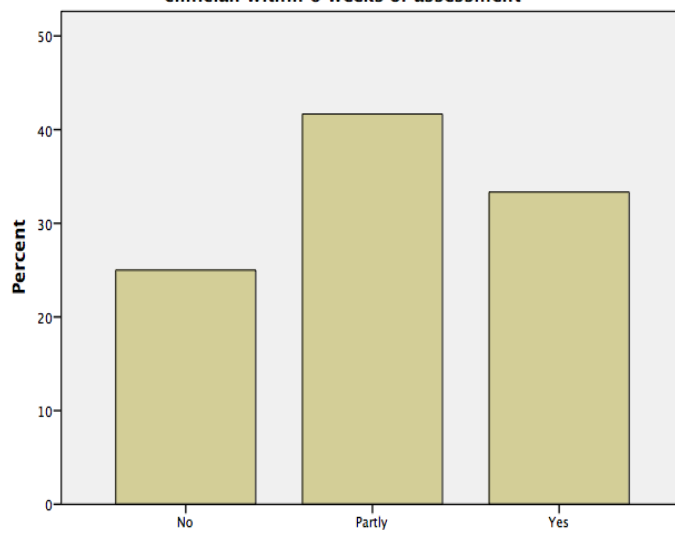
3.1.3 Where medication is used, prescribing follows protocols and best practice (e.g. NICE guidelines), and is closely monitored and regularly reviewed by an appropriately qualified, experienced practitioner

3.1.4 Young people and parents/carers can access support that is appropriate to any disabilities or needs additional to their mental health needs.



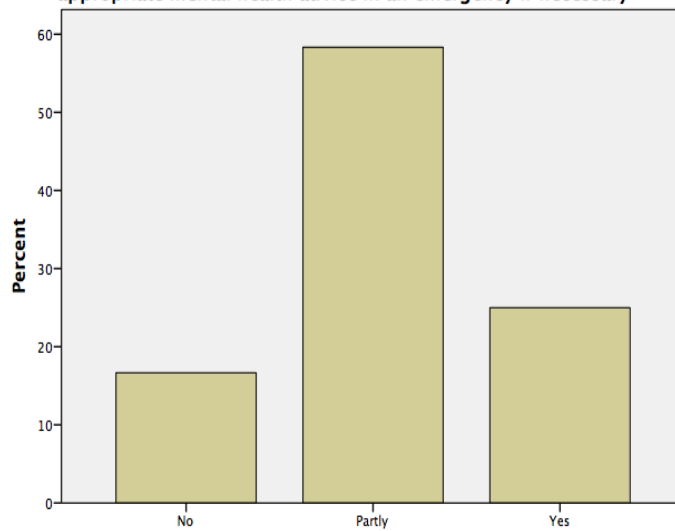
3.1.4 Young people and parents/carers can access support that is appropriate to any disabilities or needs additional to their mental health needs.

3.2.1 Young people assessed as requiring treatment see an appropriate clinician within 6 weeks of assessment



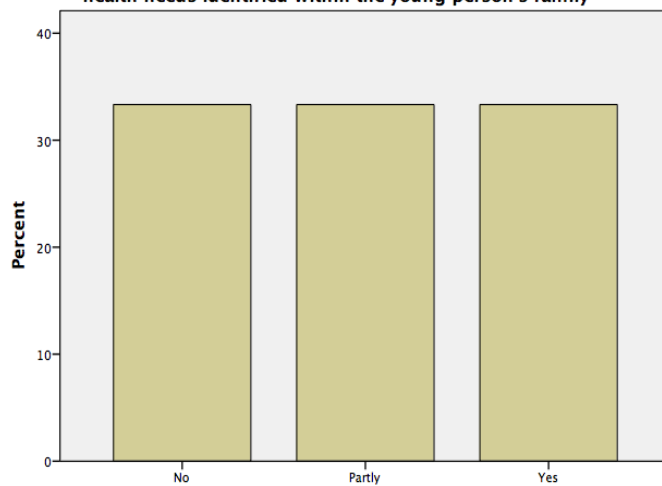
3.2.1 Young people assessed as requiring treatment see an appropriate clinician within 6 weeks of assessment

3.2.2 Young people and their parents/carers are informed of how to get appropriate mental health advice in an emergency if necessary



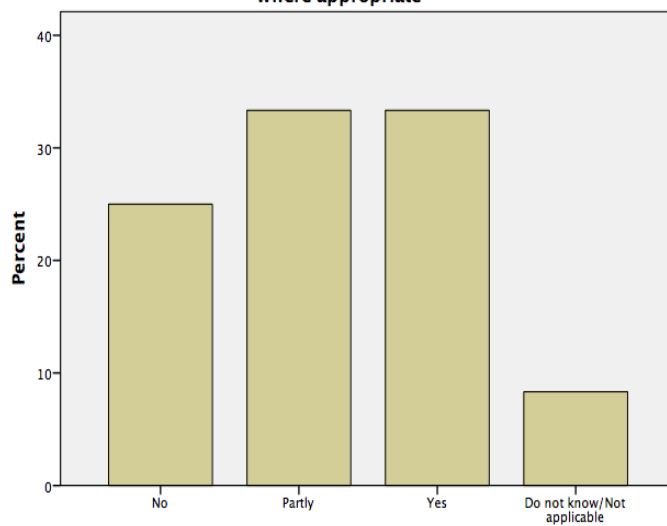
3.2.2 Young people and their parents/carers are informed of how to get appropriate mental health advice in an emergency if necessary

3.3.1 CAMHS liaise with other appropriate clinicians to meet any mental health needs identified within the young person's family



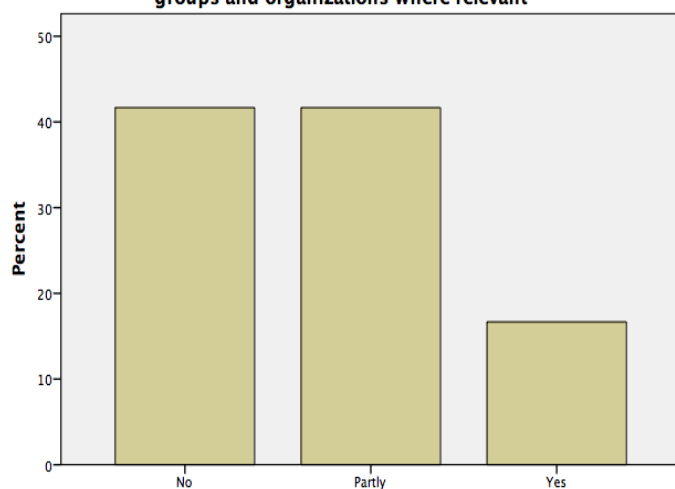
3.3.1 CAMHS liaise with other appropriate clinicians to meet any mental health needs identified within the young person's family

3.3.2 Young people and parents/carers are guided in self-help approaches where appropriate



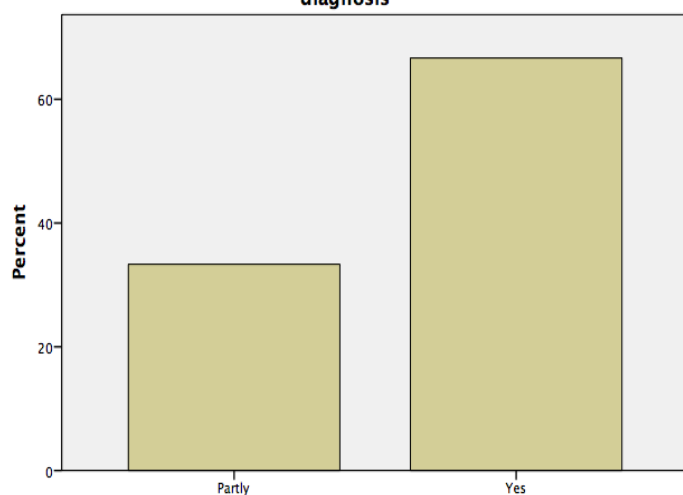
3.3.2 Young people and parents/carers are guided in self-help approaches where appropriate

3.3.3 Young people and their parents/carers are informed about local voluntary organizations and self-help groups, including culturally specific groups and organizations where relevant



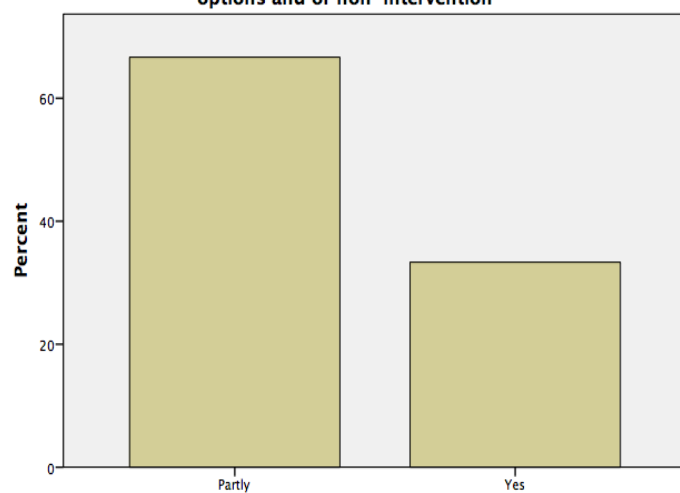
3.3.3 Young people and their parents/carers are informed about local voluntary organizations and self-help groups, including culturally specific groups and organizations where relevant

3.4.1 Young people and their parents/carers have regular discussions with clinicians about the young person's progress and, where relevant, diagnosis



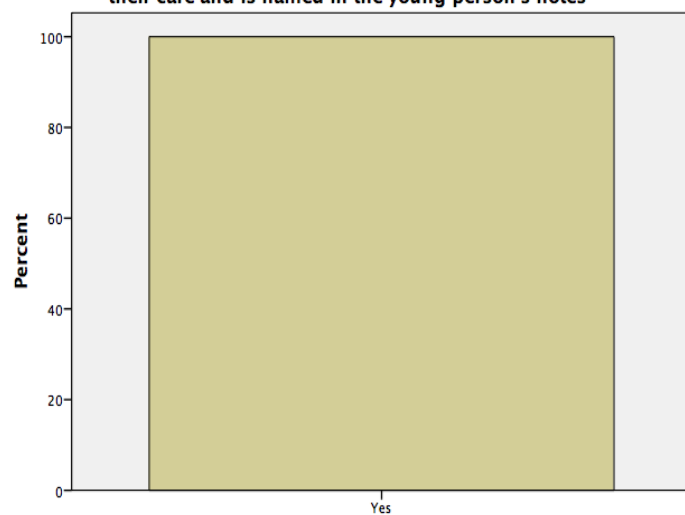
3.4.1 Young people and their parents/carers have regular discussions with clinicians about the young person's progress and, where relevant, diagnosis

3.4.2 Young people and their parents/carers are provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention



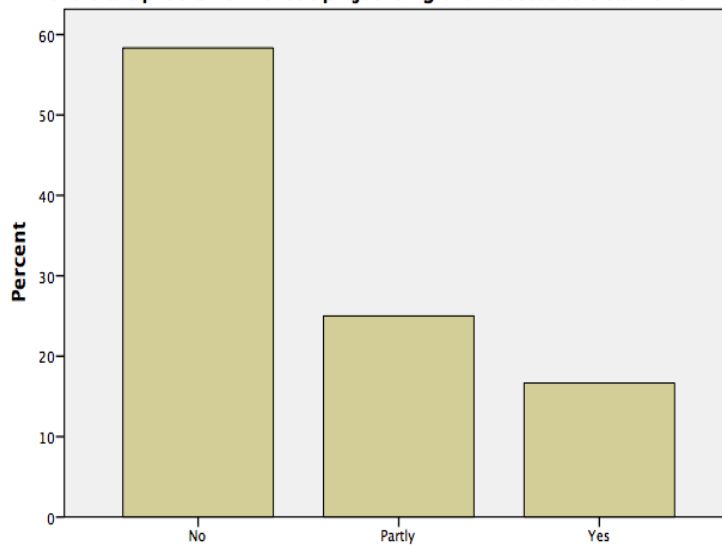
3.4.2 Young people and their parents/carers are provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention

3.4.3 All young people have a named member of staff who co-ordinates their care and is named in the young person's notes



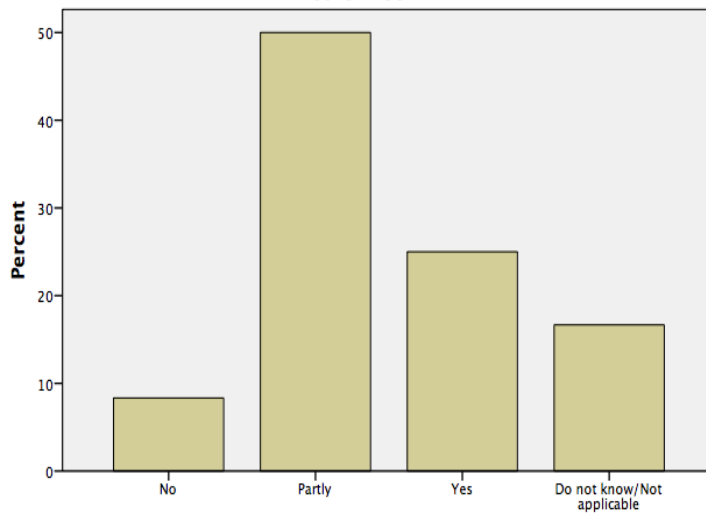
3.4.3 All young people have a named member of staff who co-ordinates their care and is named in the young person's notes

3.4.5 There is a mechanism for young people to change their clinician if there are problems without prejudicing their access to treatment



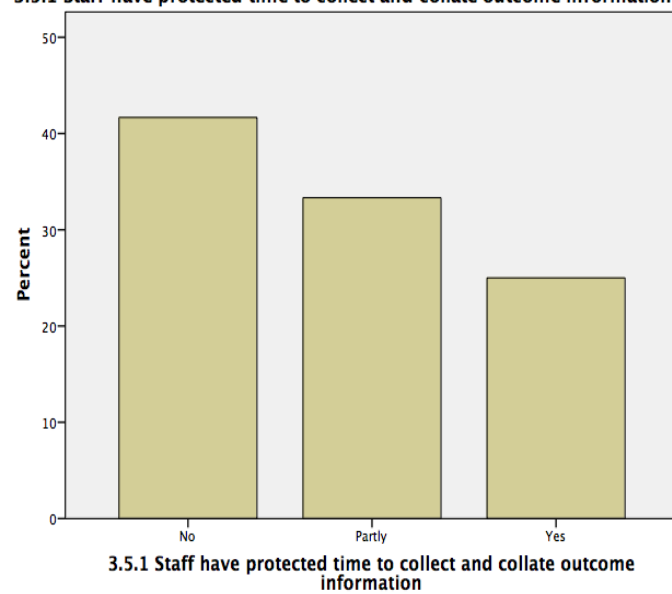
3.4.5 There is a mechanism for young people to change their clinician if there are problems without prejudicing their access to treatment

3.4.4 Young people and their parents consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise

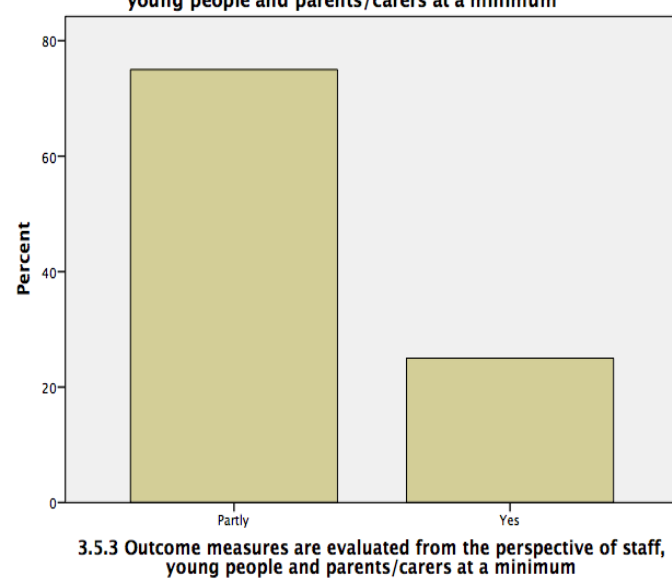


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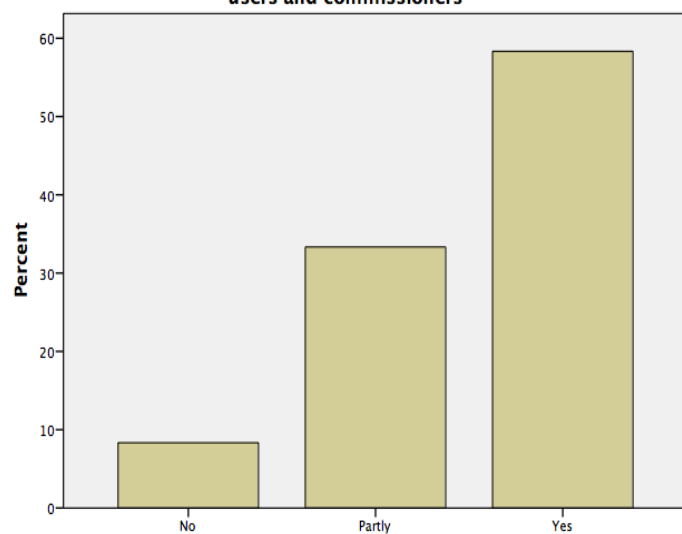
3.5.1 Staff have protected time to collect and collate outcome information



3.5.3 Outcome measures are evaluated from the perspective of staff, young people and parents/carers at a minimum

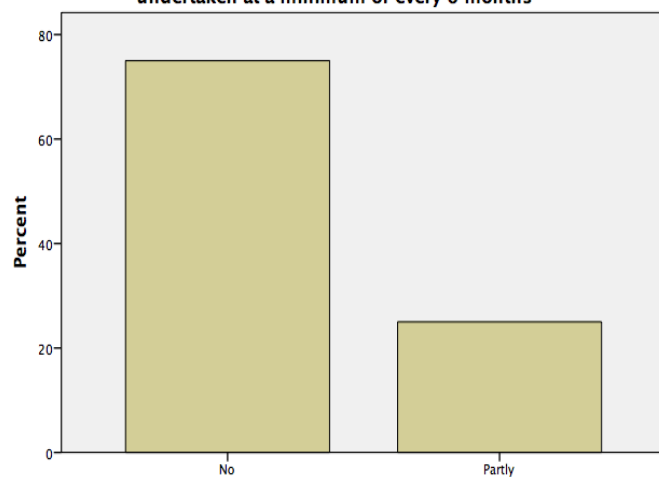


3.5.4 Information from outcome measurement is fed back to staff, service-users and commissioners



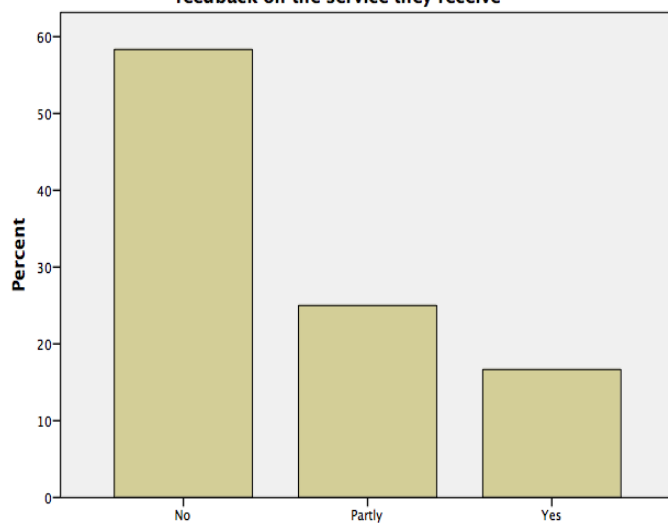
3.5.4 Information from outcome measurement is fed back to staff, service-users and commissioners

3.5.5 Aggregated outcome data is used to inform individual plans for intervention, service evaluation and development. Guidance: this should be undertaken at a minimum of every 6 months



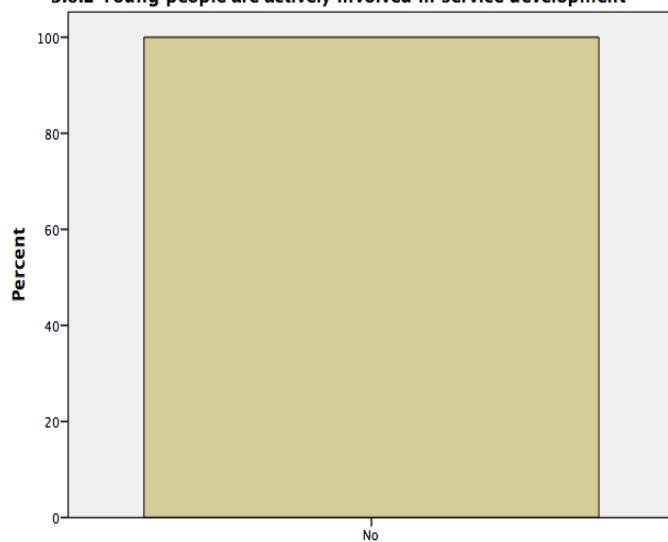
3.5.5 Aggregated outcome data is used to inform individual plans for intervention, service evaluation and development. Guidance: this should be undertaken at a minimum of every 6 months

3.6.1 Young people and parents/carers are actively encouraged to give feedback on the service they receive



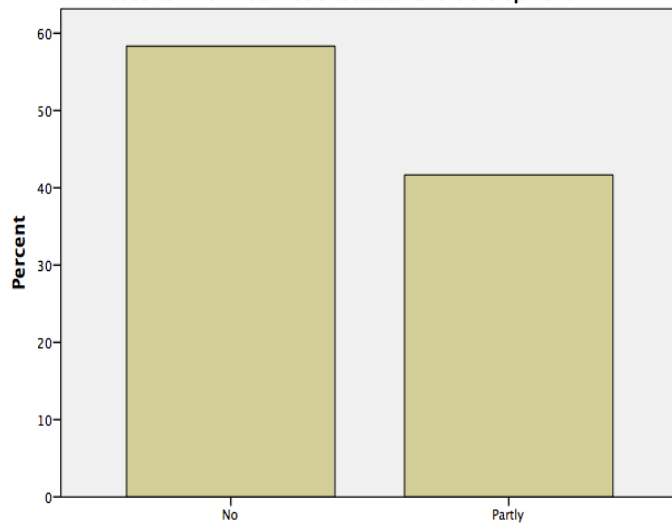
3.6.1 Young people and parents/carers are actively encouraged to give feedback on the service they receive

3.6.2 Young people are actively involved in service development



3.6.2 Young people are actively involved in service development

3.6.3 Feedback from young people and their parents is monitored and used to inform service evaluation and development



3.6.3 Feedback from young people and their parents is monitored and used to inform service evaluation and development